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Supreme Court, U.S.
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No._____

In The

Supreme Court of the United States

SALLE A. CONOVER,

Petitioner,

v.

AETNA US HEALTHCARE, INC.,
and AETNA LIFE INSURANCE COMPANY

Respondents.

Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Tenth Circuit

PETITION FOR A WRIT OF CERTIORARI

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69 pp

QUESTIONS PRESENTED

1. Is Oklahoma's common law state tort claim for insurance bad faith saved from pre-emption under the terms of the saving clause of the Employee Retirement Income Security Act of 1974 ("ERISA'), ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

2. If Oklahoma's common law state tort claim for insurance bad faith is saved from ERISA pre-emption, do the remedies it provide conflict with ERISA's remedial provisions, ERISA § 502, 29 U.S.C. § 1132 so that it would nonetheless be pre-empted.

PARTIES

The Petitioner is Sallee A. Conover ("Conover').

The Respondents are Aetna U.S. Healthcare, Inc. ; and Aetna Life Insurance Company ("Aetna').

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PETITION FOR A WRIT OF CERTIORARI

Conover respectfully submits that a writ of certiorari should issue to review the judgment of the Court of Appeals, Tenth Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals is found at 320 F.3d 1076 and reprinted in the Appendix ("App.') at Page 1a. The opinion of the lower court is published at 167 F.Supp. 2d 1317 (N.D. Okl. 2001). The Order Denying plaintiff's petition for rehearing and rehearing *en banc* is found at Page 9a.

JURISDICTION

The United States Court of Appeal's Order denying Conover's petition for rehearing and petition for rehearing en banc was filed on March 21, 2003. This petition is being timely filed within 90 days of that date. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves the following statutes: 29 U.S.C. §§ 1001; 1132; and 1142 set forth at App. 10a to 26a.

STATEMENT OF THE CASE

A. INTRODUCTION

In 1987 this Court rendered its opinion in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). In that case this Court analyzed the Mississippi bad faith law and determined that it was a law of general application that impacted on the insurance industry rather than a law that was specific to the insurance industry and was regulatory in nature. In doing so, the Court reviewed the heritage of Mississippi's contractual bad faith law and found that it had its roots in general contractual law. Petitioner believes that such an analysis under the rigid McCarran-Ferguson test applied in *Pilot Life*, the modified McCarran-Ferguson set out in *Unum Life Ins. Co. v. Ward*, 526 U.S. 899 (1999) or the most recent test adopted in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. ___, 123 S.Ct. 1471 (April 2, 2003) would have a different result if the subject was Oklahoma's insurance bad faith laws.

This is precisely what the Honorable Sven Eric Holmes did in the case of *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F.Supp. 2d. 1202 (N.D. Okla. 1999). Because space will not allow a full review of this issue, we implore the Court to read Judge Holmes' opinion. Also, Judge Holmes is so confident in his position that he has certified a question on the issue to the Oklahoma Supreme Court.

After this Court decided *Pilot Life*, it appears that virtually all of the courts throughout the United States, both at the district level and at the appellant level, believed that the question of availability of a state insurance bad faith claim was foreclosed. The Seventh Circuit even upheld sanctions for one seeking state court remedies in an ERISA case. In *Smith v. Blue Cross and Blue Shield of Wisconsin*, 959 F.2d 655 (Wis. 7th Cir. 1992), the Court determined, "This action

encompasses a classic violation of Rule 11. No reasonable attorney having read *Pilot Life* and *Taylor* could manufacture a good faith argument as to why this suit should be brought.' At 659.

Yet there has been a scattering of district courts that have listened to these "frivoulous arguments' and like Judge Holmes in *Lewis v. Aetna* determined that the state insurance bad faith law that was being examined was saved from ERISA pre-emption. In addition to Judge Holmes' opinion, we have the case of *Hamilton v. United Healthcare of Louisiana, Inc.*, 2001 W.L. 536300; *Selby v. Principal Mutual Life Ins. Co.*, 2000 W.L. 178191 (S.D.N.Y. 2000); *Colligan v. UNUM Life Insurance Co. of America*, 2001 W.L. 533 742 (D. Colo. 2001); *Gilbert v. Alta Health and Life Ins. Co.*, 122 F.Supp. 2d 1267 (N. D. Ala. 2001); *Norman v. Paul Revere Life Ins. Co.*, 2000 W.L. 33316829 (W.D. Was. 2000) and *Rosenbaum v. UNUM Life Ins. Co. of America*, 2002 W.L. 1769899, 28 Employee Benefit Cas. 2002 (E.D. Pa. 2002).

In the case of *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002), a three judge panel discussed four (4) post-*Pilot Life* cases decided by this Court and then stated,

> "If we were writing on a clean slate, or deciding this *en banc*, the Roarks would have a strong case against ERISA preemption. But, as a panel, we are bound by *Corcoran*, accordingly, we affirm with respect to the Roarks.' At 307.

Thus, we have one appellant court finding that the mere bringing of a state court cause of action in an ERISA context is sanctionable under Rule 11 and then we have other courts looking at the state law with new eyes and determining they meet the saving clause requirements.

This Court has made three important and significant decisions since *Pilot Life*. The first was *UNUM Life Ins. of America v. Ward*, 526 U.S. 358 (1999). It is the less rigid application of the McCarran-Ferguson that most of the courts above use in determining that the applicable state bad faith law was saved from ERISA pre-emption. That case also called into question whether the discussion in *Pilot Life* regarding conflict pre-emption was part of the holding or merely *dicta*. In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), the Court made it clear that the discussion in *Pilot Life* regarding conflict pre-emption was simply *dicta* and found it unnecessary in that case to turn that *dicta* into a holding.

A review of the opinion that is being appealed from treats the *Pilot Life dicta* as a mandatory holding. Indeed, a review of the opinion will indicate that a good portion of it is based upon this conflict pre-emption analysis.

Although this Court has declared part of *Pilot Life's* reasoning *dicta* and abandoned the test utilized by the *Pilot Life* court for another, the *Pilot Life* case continues to affect ERISA jurisprudence more than any other case.

B. FACTUAL BACKGROUND

Plaintiff Sallee Conover was employed by Harcourt General, Inc. Group who had a "certificate of coverage' with the defendant Aetna U.S. Healthcare that included, among other benefits, disability insurance. On November 12, 1997, the plaintiff was involved in an accident that rendered her totally disabled. She was certified as disabled on July 13, 1998. Based upon a functional capacity evaluation, it was determined that she could perform the material duties of her occupation with her employer. Plaintiff was notified of the suspension of her benefits on August 6, 1999. Plaintiff maintained that she continued to be disabled.

C. TRIAL COURT PROCEEDINGS

Petitioner filed a suit in the district court of Tulsa County, State of Oklahoma, alleging breach of contract and insurance bad faith. That suit was removed to federal court. At the regularly scheduled case management conference the trial court ordered briefing on two issues - - Whether ERISA pre-empts plaintiff's state law claims and whether a jury trial is permitted. The Court ruled on these preliminary issues in the published opinion of *Conover v. Aetna U.S. Healthcare, Inc.*, 167 F.Supp. 2d 1317 (N.D. Okl. 2001) that the plaintiff's state bad faith insurance claim was pre-empted by ERISA. Judge Brett's opinion indicates why this Court needs to address the issues presented. The Court stated in his opinion:

> "[t]he pertinent issue in determining whether plaintiff's state law claims are pre-empted is whether the United States Supreme Court in *UNUM Life Ins. Co. of America v. Ward,* 526 U.S. 358, 119 S.Ct. 1380, 143 L.Ed 2d 462 (1999) alters the binding precedent of *Gaylor v. John Hancock Mutual Life Ins. Co.,* 112 F.3d 460 (10th Cir. 1997).' At 1318.

The Court went on to state that *Gaylor* held that Oklahoma's bad faith law did not sufficiently regulate insurance that it would fall within ERISA's saving clause and in holding the court applied the test set forth in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) indicating that the analysis was based on the three McCarran-Ferguson factors. Judge Brett further recognized that Judge Holmes of the same court held in *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F.Supp. 2d 1202 (N.D. Okla. 1999) that the UNUM test superceded or altered *Gaylor's* holding that Oklahoma's bad faith law is pre-empted by ERISA. The Court went on to state:

> "[w]hile the Tenth Circuit in *Gaylor* applied a less

> 'supple' test in its analysis of Oklahoma's bad faith rule that applied in *UNUM* to the California's Notice-Prejudice Rule, the court is not persuaded the *Gaylor* test is enough at odds with *UNUM* to free the court from *Gaylor's* dictates.' At 1320.

Interestingly enough in his opinion at Footnote No. 6, Judge Brett states as follows:

> "The court questions the relevance of a conflict with the civil enforcement provisions of ERISA in a state-law exemption analysis. Under ERISA, a state law which regulates insurance is expressly exempted from pre-emption. ERISA does not dictate a state law which regulates insurance is exempt *unless* it provides a state law cause of action or remedy. *See UNUM,* 526 U.S. at 377 N.7, 119 S.Ct. 1380 (discussing but not deciding the issue).' At 1320, N. 6, (Emphasis Court's).

After the court's ruling, the parties settled the contractual claim with the plaintiff's right to pursue appeal on the dismissed causes of action.

D. APPELLATE PROCEEDINGS

Conover appealed the dismissal of her state cause of action for insurance bad faith as well as her quest for a common law remedy.

The petitioner presented the same argument that was presented to Judge Holmes in the *Lewis v. Aetna, supra,* case. However, the three judge panel, like Judge Brett, found that they were bound by the decision in *Gaylor, supra.*

> "This Court addressed this issue in *Gaylor v. John Hancock Mutual Life Ins. Co.,* 112 F 3d. 460, 466 (10th Cir. 1997), holding 'Oklahoma's bad faith does

> not sufficiently regulate insurance such that it falls within [the Act]'s saving clause.' We are bound by this decision. *See Burlington N. & Sante Fe Ry. Co. v. Burton,* 270 F.3d 942, 947 (10th Cir.) *cert. denied,* 436 U.S. 959, 112 S.Ct. 2664, 153 L.Ed. 2d 838 (2002).' At 1079.

The most disturbing part of the opinion, however, deals with the court's analysis of the conflict pre-emption issue. This case was briefed prior to this Court's decision in *Rush Prudential HMO, Inc. v. Moran*, 112 S.Ct. 2151 (2002). The *Conover* court stated, "[a] state law otherwise regulating insurance within the meaning of Section 514(b)(2)(A) may still be pre-empted if it allows plan participants and beneficiaries 'to obtain remedies under state law that Congress rejected in [the Employee Retirement Income Security Act].' At 1078. The Court cited *Pilot Life, supra,* and *Rush Prudential, supra,* as authority for this. The Court went on to state in Footnote No. 2 as follows:

> "Miss Conover suggests the Supreme Court impliedly overruled this portion of *Pilot Life's* decision in *Ward*, 526 U.S. at 376, N. 7, 119 S.Ct. 1380. We disagree for three reasons. First, the Supreme Court instructed us to avoid concluding its 'more recent cases had by implication, overruled an earlier precedent' *Agostini v. Felton,* 521 U.S. 203, 237, 117 S.Ct. 1997, 138 L.Ed. 2d 391 (1997). Rather, we 'should follow the case which directly controls, leaving to [the Supreme] court of overruling its own decisions.' *Id.* (Quotation marks and citations omitted). Second, the court in *Ward* noted but did not address the solicitor general's argument that *Pilot Life* does not hold a state law regulated insurance is nevertheless pre-empted if it provides a state law cause of action or remedy. *See*

> *Ward,* 526 U.S. at 376, N. 7, 119 S.Ct. 1380. Third, the Supreme Court reaffirmed this portion of the *Pilot Life* decision in a later decision, stating a state law is pre-empted if it '**allows plan participants to obtain remedies . . . that Congress rejected [the Employee Retirement Income Security Act**]. *Rush Prudential,* 122 S.Ct. at 2165 (Quoting *Pilot Life,* 481 U.S. at 54, 107 S. Ct. 1549.' 1079 Fn. 2. (Emphasis added).

The quotation from *Rush Prudential* is incomplete. The full quotation is "[a]lthough we have yet to encounter a forced choice between the Congressional policies of exclusive federal remedies and the 'reservation of business of insurance to the states, ' *Metropolitan Life,* 471 U.S. at 744, N. 21, 105 S.Ct. 2380, **we have anticipated such a conflict with the state insurance regulation losing out if it allows plan participants to obtain remedies . . . that Congress rejected in ERISA,"** *Rush Prudential*, 122 S.Ct. at 2165 (Emphasis added, Fn 2 of the *Conover* opinion).

REASONS THE PETITION SHOULD BE GRANTED

1. THE SAVING CLAUSE IS AN INTEGRAL PART OF THE ERISA STATUTE AND IT IS TIME TO DETERMINE IF ALL STATE INSURANCE LAWS ARE SAVED FROM ERISA PRE-EMPTION.

In the case of *Metropolitan Life Ins. Co. v. Massachusetts*, 107 S.Ct. 2380, 85 L.Ed 2d 728 (1985), this Court discussed the history of both the pre-emption clause and the saving clause as they moved through Congress and then made this declaration at Footnote 29 of the opinion, "The change gave the insurance saving clause a much more significant role, **as a provision that saved an entire body of law from the sweeping general pre-emption clause."** 85

L.Ed 2d at 744 (Emphasis added). The Court went on to state in the body making this declaration,

> "We therefore decline to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer clause' which modifies it. If a state law 'regulates insurance,' as mandated-benefit laws do, it is not pre-empted. Nothing in the language, structure or legislative history of the Act supports a more narrow reading of the clause, whether it be the supreme judicial court's attempt to save only state regulations unrelated to substantive provisions of ERISA, or the insurer's more speculative attempt to read the saving clause out of the statute.' 84 L.Ed 2d at 744.

Despite this declaration a significant portion of the entire body of state insurance law that was saved has been pre-empted by what now appears to be *dicta* in the case of *Pilot Life, supra.*

In the 1974 U.S. Code and Administrative News, in its final report the Committee stated as follows:

> "The enforcement provisions have been designed specifically to provide the secretary and the participants and their beneficiaries with broad remedies for redressing or permitting violation of the Retirement Income Security for Employees Act as well as the amendments made to Welfare Pension Disclosure Act. **The intent of the committee is to provide the full range of legal and equitable remedies available both in state and federal courts and to remove jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of fiduciary responsibilities under state law for recovery of**

benefits due to participants." 1974 U.S. Code and Administrative News, Page 4655.

In *Metropolitan Life Ins. Co., supra*, this Court declared, "[t]he presumption is against pre-emption and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope.' *Metropolitan Life Ins. Co.*, 471 U.S. at 741.

In regard to insurance law, we not only have a law that is traditionally one reserved to the states but one the ERISA statute specifically saves.

Congress conferred jurisdiction on both state and federal courts for actions brought by plan participants and beneficiaries to collect benefits. 29 U.S.C. § 1123(e)

We have already discussed the fact that a three judge panel of the Fifth Circuit believes that these types of actions might be saved if they were allowed to review the case either *en banc* or were not bound by prior precedents.[1]

In the case of *Arana v. Oschner Health Plan, Inc.*, 302 F. 3d 462 (C.A. 5 2002), another Fifth Circuit panel remanded a case back to state court because the defendant sought relief that was unavailable under ERISA § 502(a)

It simple appears that there is no consensus on what the status of the law is at this particular point. Some courts feel that the decisions of this Court after *Pilot Life* have changed the law enough that they are no longer restrained by prior precedent that relies solely on the *Pilot Life* decision. Other courts see merit in the arguments offered in support of the proposition that some state insurance laws might be saved but feel they are restrained by prior precedent that relied on *Pilot*

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[1] *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002).

Life. At least one court thinks that the pursuit of a state law bad faith claim is sanctionable under Rule 11. Obviously, there is enough confusion and this is a question of such importance and there is so much litigation going on regarding this issue, this Court should grant certiorari.

2. THE PRE-EMPTION OF SAVED STATE INSURANCE LAW THAT PROVIDES REMEDIES AND SANCTIONS FOR IMPROPER WITHHOLDING OF BENEFITS DEFEATS THE VERY PURPOSE FOR WHICH ERISA WAS PASSED.

In *Bast v. Prudential Ins. Co.*, 150 F.3rd 1003, 1005 (9th Cir. 1998) *Cert. Den.* 120 S.Ct. 170 (1999), the Court stated, "Although this case presents a tragic set of facts, the district court properly concluded that under existing laws the Basts are left without a remedy.' In that case Rhonda Bast was diagnosed with a secondary malignancy in her left lung. Her oncologist recommended that she undergo an autologous bone marrow transplant procedure ("ABMT'). Prudential informed the oncologist that her bone marrow transplant was not covered by the plan on September 13, 1991. With the help of an attorney and her doctors, Prudential finally relented and on February 28, 1992, approved the ABMT procedure. The spread of the cancer disqualified her for the ABMT and her health declined. She died in January 1993.

In *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1331, 1338 (5th Cir. 1992), the Fifth Circuit said, "The result ERISA compels us to reach means the Corcorans have no remedies state or federal, for what may have been a serious mistake.' The serious mistake in that case included not giving Florence Corcoran temporary disability benefits for the remainder of her pregnancy despite her doctor recommending she have complete bed rest during the final months of her pregnancy. Again, the benefits were denied

after a second doctor reviewed Mrs. Corcoran's medical records and suggested "The company would be at considerable risk denying her doctor's recommendations.' At 1322. During a period of time when no nurse was on duty, the fetus went into distress and died.

In *Andrews-Clarke v. Travelers Ins. Co.*, 984 F.Supp. 49, 52-53, 56 D.Mass. 1977, the Court noted, "The tragic events . . . cry out for relief. . . . ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans. It is therefore deeply troubling that, in the health insurance context, ERISA has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect. What went wrong?' The facts that prompted the trial court to ask that question of what went wrong is that Richard Clarke drank to excess. He had a benefit that allowed enrollment in a thirty day treatment center. That benefit was denied three separate times. On the third, Travelers "incredibly refused to authorize . . . a private admission' At. 52. While in a county facility, he was forcefully raped and sodomized by another inmate in his unit. He received little in way of therapy or treatment and less than a month later, he committed suicide. All of this after being denied a defined policy benefit.

In the case of *Florence Nightingale Nursing Serv., Inc. v. Blue Cross and Blue Shield*, 832 F.Supp. 1456, 1457 (N.D. Ala. 1993), *Aff'd.* 41 F.3d 1476, 11th Cir. 1995, the Court stated, "This Court is willing to believe that ERISA has lurking somewhere within it redeeming features.' In that case, no one died, the insurance company simply wanted to pay a ridiculous and arbitrary amount for the services of nursing personnel doing jobs most of us could not stomach.

Finally, in the Tenth Circuit we have the case of *Cannon*

v. Group Health Serv. of Oklahoma, Inc., 77 F . 3rd 1270, 1271 (10th Cir. 1996), stating, "Although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted we conclude that the law gives us no choice but to affirm' the grant of summary judgment to the insurer.' This is another case where the carrier denied ABMT to a leukemia patient. This time because it was declared experimental. The decision was reversed over a year later but too late. She died.

Thus, in these cases we have two women dead of cancer, a hopeless alcoholic committing suicide because he was refused a defined benefit that he obviously needed, a dead baby and a health care provider trying to get a proper wage. What these cases demonstrate is that if you withhold the benefit long enough until the beneficiary dies, then you do not have to pay anything. It will be argued in a moment that the only way ERISA can work the way it was designed to work is in conjunction with saved state insurance law. Indeed, ERISA does not purport to regulate insurance at all. As the law now stands, an insurance company that underwrites employee benefits and makes claims determinations does so without any regulation whatsoever. This Court all but said as much in the case of *Pegram v. Herdich* , 430 U.S. 211 (2000).

3. OKLAHOMA'S BAD FAITH LAW IS SAVED FROM ERISA PRE-EMPTION

In *Christian v. American Home Assur. Co.*, 1977 Okl. 1471, 577 P.2d 899., the Oklahoma Supreme Court expanded the *quasi* contractual tort of insurance bad faith extending it to all first party claims and expanding the type of damage that can be recovered. First, the Oklahoma Supreme Court in *Christian* recognized that it was merely an extension of already existing law, not based on general contract principals

but based on the special relationship between an insurer and an insured. In extending the obligation of good faith and fair dealing to all insurance contractual situations, the Oklahoma Supreme Court stated as follows:

> "[12] We have previously held that insurance companies have a duty to act in good faith and fair dealing with their insureds when handling claims made against insureds by third parties. For the breach of this duty, we have imposed liability against the insurer for amounts in excess of the policy limits. *American Fidelity and Casualty Co. v. L.C. Jones Trucking Co.,* Okl., 321 P.2d 685, (1958); *National Mutual Casualty Co. v. Britt*, 203 Okl. 175, 200 P.2d 407 (1948).' At 902.

Thus, we see that the law of *Christian* has its root in prior insurance law and not general contractual law. A review of *American Fidelity and Casualty Co. v. L.C. Jones Trucking Co.,* 1957 Ok 287, 321 P.2d 685, (1958) and *National Mutual Casualty Co. v. Britt,* 203 Okl. 175, 200 P.2d 407 (1948), show that it is the special relationship between insurer and insured that creates that relationship. Indeed, the Oklahoma Supreme Court discussed that relationship back in 1948 when it stated as follows:

> "Their relations became mutually fiduciary; and each owed the other the duty of upmost good faith in their dealings together, and in exercising the privileges and discharging the duties specified in and incident to the policy contract. The plaintiff (insured) engaged to cooperate with the company if a loss threatened. He was bound to do so honestly and with all good fidelity. The company was equally bound to so handle the *Rule* case [*Rule v. Johnson*, 104 Vt. 486, 162 A. 384]. It had a right to look after

its own interest, but it was bound to have due regard for the plaintiff's interests as well.

An insurer . . . is bound to give the rights of the insured at least as much consideration as it does its own in determining whether or not to affect a settlement.' *National Mutual Cas. Co. v. Britt,* 203 Okl. 175, 200 P.2d 407, 411 (Okl. 1948).

Secondly, the purpose of *Christian* is to regulate the insurance industry. It homes in on the insurance industry and we see this from the following quotation:

"[11] We have recognized the *quasi*-public nature of insurance companies and the need to subject the companies to state control for the protection and benefit of the public. *Oklahoma Benefit Life Ass'n v. Bird*, 192 Okl. 288, 135 P.2d 994 (1943). Perusal of our insurance code, Title 36 Oklahoma Statutes, reveal extensive government regulation of the industry in this state.' At 902.

The *Christian* cause of action is one that is directed solely to the insurance industry in an effort to regulate the insurance industry.

On numerous occasions Plaintiffs have sought to extend the *Christian* cause of action to settings and relationships other than that between insurer and insured. In the case *Rodgers v. Tecumseh Bank*, 1988 Okl.36, 756 P.2d 1223, the Supreme Court refused to apply the doctrine in a situation between a lender and a bank. In doing so, the Court stated as follows:

"In their primary allegation of error, the borrowers urged the court, principally on public policy grounds, to extend to this debtor-creditor relationship our holding in *Christian v. American Home Assurance*

> *Co.* In that case we stated, 'An insurer has an implied duty to deal and act in good faith with its insured and the violation of this duty gives rise to an action in tort for which consequential and, in proper cases, punitive damages may be sought'.
>
> While *Christian* dealt with group disability insurance contracts, in *McCorkle v. Great Atlantic Insurance Co.*, we extended the implied-in-law duty of good faith and fair dealing to include all types of insurance contracts. However, we refuse to extend this duty to strangers to the contract in *Timmons v. Royal Globe Insurance Co.*, and *Christian* and its progeny, thus far, only apply against insurers.' At 1225.

Likewise, in the case of *First Nat. Bank and Trust v. Kissee*, 1993 Ok. 96, 859 P.2d 502, the Oklahoma Supreme Court re-emphasized its position that a *Christian* cause of action does not apply to other contractual relationships. It did, however, point out that there can be tortious breach of contract but it is much different than the *Christian* cause of action. In doing so, the Court stated as follows:

> "We strongly agree that guarantor's primary contention that banks have an obligation to exercise good faith and fair dealing with its customers. The common law imposes the implied covenant upon all contracting parties, that neither party, because of the purposes of the contract, will act to injure the parties' reasonable expectations nor impair the rights or interests of the other to receive the benefits flowing from their contractual relationship. However, what guarantor fails to recognize is that in *Rodgers v. Tecumseh Bank,* this Court held that without 'gross recklessness or wanton negligence on behalf of a party' to a commercial contract, a breach of the

implied covenant of good faith and fair dealing merely results in a breach of contract.

We made it clear in *Rodgers*, that our seminal holding in *Christian v. American Home Assurance Co.*, does not generally apply to the relationship between a bank and its customer. In *Christian*, this Court held that in an insurance context, a breach of the implied covenant of good faith and fair dealing by the insurance carrier 'gives rise to an action in tort for which consequential, and in a proper case, punitive damages may be sought' by the insured. In *Rodgers*, we emphasized the *special relationship* between an insurer and insured which differentiates insurance contracts from commercial contracts. Our reluctance to extend *Christian* and its progeny beyond the insurance field was also illustrated in *Hinson v. Cameron*, where this Court refused to apply *Christian* to an at-will employment relationship. Again, we refuse to expand our *Christian* holding to banking relationship.' At 509 (Emphasis Court's).

It is important to understand that although the *Christian* cause of action may have some principals in general contract law, it is not an extension of contractual law to insurance contracts but is a separate and distinct cause of action that applies only to insurance contracts, homes in on insurance contracts and is designed to regulate the insurance industry.

In addition to the *Christian* cause of action not extending to other contracts, it does not even extend to every individual entitled to payment under an insurance contract. In the case of *Allstate Ins. Co. v. Amick*, 1984 Ok. 15, 681 P.2d 362, the Oklahoma Supreme Court refused to extend the cause of action to the benefit of third party claimants. In that case, the plaintiff was a third party claimant seeking damages against an

Allstate insured under a compulsory liability policy. The plaintiff may eventually be entitled to insurance proceeds by virtue of their cause of action against the insured of Allstate Insurance Company. The Oklahoma Supreme Court found that they were not entitled to the benefit of a *Christian* type cause of action. In denying that cause of action to third party claimants, the Supreme Court made the following observation:

> "[12] Prior to *Christian*, we had recognized insurers' duty to act in good faith and fair dealing with its insureds only as far as handling claims by third parties against the insured. We recognize a duty to accept reasonable settlements and act in good faith toward the insured and for the breach of this duty we impose liability in excess of policy limits. *American Fidelity and Casualty Co. v. L.C. Jones Trucking Co., Okl.*, 321 P.2d 685 (1985); *National Mutual Casualty Co. v. Britt*, 203 Okl. 175, 200 P.2d 407 (1948).
>
> "[13] In *Christian*, this recognized duty of dealing fairly and acting in good faith with the insured was simply applied to claims of the insured itself.
>
> "[14] This single duty of dealing fairly and in good faith with the insureds arises from the contractual relationship. In absence of the contractual or statutory relationship, there is no duty which can be breached.' *Allstate Ins. Co. v. Amick*, 1984 Ok. 15, 681 P.2d 362.

Again, we see from the above quote that the *Christian* cause of action has its roots firmly based in insurance law.

Finally, we see a close relationship between a *Christian* cause of action and statutory regulation. In *Christian* the Oklahoma Supreme Court stated as follows:

> "[20] With all due respect to the brethren of the federal bench, we find the obligation of an insurer to

its insured upon proper presentation of a valid claim under a disability policy, is not limited to the payment of money only.

[21] Our Insurance Code requires insurance companies to make *immediate* payment of claims. Title 36 O.S. 1971 § 4405 A 8, requires the following provision to be included as a standard clause in all individual accident and health policies:

'**TIME OF PAYMENT OF CLAIMS**: Indemnities payable under this policy for any loss . . . will be paid immediately upon receipt of due written proof of such loss.'

[22] This statutory duty imposes upon insurance companies to pay claims immediately, recognizes that a substantial part of the right purchased by an insured is the right to received the policy benefits promptly. Unwarranted delay precipitates the precise economic hardship the insureds sought to avoid by purchase of the policy.' *Christian*, 577 P.2d at 903.

Turning now from the McCarran-Ferguson test set out in *Pilot Life*, we turn to more recent pronouncements by this Court. In *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), this Court determined that California's Notice-Prejudice Rule was saved from ERISA pre-emption. In doing so, it told us that we should apply a more supple test to determine whether or not a law is an insurance law. We look at this case and its analysis of California law because of the way that the Tenth Circuit has continued to take one small portion of the *Christian* opinion out of context. The *Christian* case quoted the case of *Gruenberg v. Aetna Insurance Company*, 9 Cal. 3d 566, 510 P.2d 1032 (1973), in adopting the cause of action we now discuss. That case in turn quoted two excess liability bad faith cases just as *Christian* did. Those cases were *Crisci v.*

Security Ins. Co., 66 Cal. 2d 428, 58 Cal. Rptr. 13, 426 P.2d 173 (1967) and *Comunale v. Traders and General Ins. Co.*, 50 Cal. 2d 654, 328 P.2d 198 (1958). In *Comunale*, the Court stated in part, "There is an implied covenant of good faith and fair dealing in every contract (including insurance policies) that neither party will do anything which will injure the rights of the other to receive the benefit of the agreement.' *Comunale*, 328 P.2d at P. 2000. This was quoted in *Christian,* 577 P.2d at 904. Based upon this quote within a quote, the Tenth Circuit has declared *Christian* to be a general contract law. In reviewing the Notice-Prejudice Rule which is a common law rule developed just like the *Christian* tort, the Court was faced with an argument from the defense that the Notice-Prejudice Rule was a rule of general application because of similarity to the maxim that "law abhors a forfeiture'. This Court responded as follows:

> "It is no doubt true that divest California decisions bears out the maxim that 'law abhors a forfeiture' and that the Notice-Prejudice Rule is an application of that maxim. But it is an application of a specific order, a rule mandatory for insurance contracts, not a principal a court pliably employ when the circumstances so warrant.' At 1387.

Of course, this same thing can be said of the *Christian* cause of action. Obviously, there is an implied covenant of good faith and fair dealing in every contract. But the way it is applied in an insurance contract in Oklahoma is a law of a specific order. What this Court said about California's Notice-Prejudice Rule could also be said about the Oklahoma tort of insurance bad faith:

> "The rule, by its very terms, 'is directed specifically at the insurance industry and is applicable only to insurance contracts.' . . . , [O]ur survey of California

> law reveals no case where the state court applied the Notice-Prejudice Rule as such outside the insurance area. Nor is this surprising, given that the rule is stated in terms prejudice to an 'insurer' resulting from untimely notice.' The rule thus appears to satisfy the common-sense view as a regulation that hones in on the insurance industry and does 'not just have an impact on [that] industry. *Pilot Life,* 481 U.S. at 50, 107 S.Ct. 1549. " At 1387.

Most recently this Court has completely abandoned the McCarran-Ferguson test for a new test. In *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471 (April 02, 2003), this Court declared,

> "Today, we make a clean break from the McCarran-Ferguson factors and hold that for a state law to be deemed a 'law . . . which regulates insurance' under Section 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. See *Pilot Life, supra,* at 50, *UNUM, supra,* at 368, *Rush Prudential, supra,* at 366. Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured. Kentucky's law satisfies each of these requirements.' At 1478.

Found at Footnote 3 of the opinion is the most important aspect of this holding as it pertains to this inquiry. The Court goes back to discuss its ruling of *UNUM Life of America v. Ward, supra*, that we just discussed. In that opinion, this Court never reached the question of whether or not the Notice-Prejudice Rule had the affect of spreading the risk. It felt that the other two McCarran-Ferguson factors were securely met. This spreading the risk factors has always been, to a certain

extent, the most bothersome of the factors. However, this clarification and revisiting of the Notice-Prejudice Rule shows that Oklahoma's insurance bad faith meets this requirement. In Footnote No. 3 the Court declared,

> "While the Ninth Circuit concluded in *Cisneros v. UNUM Life Ins. Co.,* 134 F.3d 939, 945-946 (1998), aff'd in part, rev'd and remanded in part, *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 899, 119 S.Ct. 1380, 143 L.Ed 2d 462 (1999), that the 'Notice-Prejudice Rule does not spread the policyholders risk within the meaning of the first McCarran-Ferguson factor,' our test requires only that the state law substantially *affect* the risk pooling arrangement between the insurer and insured; it does require that the state law actually spread the risk. See *Ante*, at 1477-1478. The Notice-Prejudice Rule governs whether or not an insurance company must cover a claim submitted late, which dictates to the insurance company the conditions under which it must pay for the risk that it has assumed. This certainly qualifies as a substantial affect on the risk pooling arrangement between the insurer and the insured.' At 1478.

The case of *First Bank of Turley v. Fidelity Deposit Ins. Co. of Maryland*, 1996 Ok. 105, 928 P.2d 298, is one of the many cases where the Oklahoma Supreme Court declined to extend the *Christian* cause of action beyond the insurance context. In doing so, the Court stated,

> "A *Christian* claim rests on the insurer's implied-in-law duty to act in good faith and deal fairly with the insured to the end that policy benefits are received . . . The *Christian* cause of action crafted as it is from the insured/insurer relationship, flows not so much from the contract as it does from the law that attaches a

> cluster of implied-in-law duties to the insurer-insured status.' 925 P.2d at 307.

In other words, all of those laws that would dictate the terms under which an insurer would pay a claim are merged into the *Christian* doctrine.

The *Christian* cause of action satisfies both prongs of the new test created in *Kentucky v. Miller, supra.*

4. AS A SAVED INSURANCE LAW, THE OKLAHOMA CAUSE OF ACTION FOR INSURANCE BAD FAITH DOES NOT CONFLICT WITH ERISA'S REMEDIAL PROVISIONS.

Petitioner's basic argument is that only through state regulation can ERISA achieve its goals. "The basic goal of ERISA was the protection and enhancement of the delivery of promised benefits.' *Polk, ERISA Prac. and Lit.,* Section 1:01. In the case of *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989), the Court stated:

> "ERISA was enacted 'to promote the interest of employees and their beneficiaries in employee benefit plans,' *Shaw v. Delta Airline, Inc.*, 463 U.S. 85, 90 (1983), and 'to protect and contractual define benefits; *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. at 148. See generally 29 U.S.C. § 1001. (setting forth congressional findings and declarations of policies regarding ERISA). Adopting *Firestone*'s reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.' 489 U.S. at 113.

Unfortunately, that is exactly what happened. No one can state with a straight face that employees and their beneficiaries

enjoy more protection under ERISA than they did before ERISA was enacted and interpreted in the way that it has been.

In *Pegram v. Herdich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed. 2nd 164 (2000), this Court ruled that an HMO making a mixed medical and claims decision could not be held liable under 29 U.S.C. § 1109(a) for breach of a fiduciary duty. If the logic extends to pure claims decisions, we will have a situation where the insurance claims administrator is given fiduciary deference without the offsetting liability.

In *California Federal Savings and Loan Association v. Guerra*, 479 U.S. 272, 281, 107 S.Ct. 683, 93 L.Ed. 2nd 613 (1987), we are told that conflict preemption occurs when, although not expressly displaced by Federal statute, a state law regulation so conflicts with federal law, that the Supremacy Clause of the Constitution compels preemption. "Such a conflict occurs either because 'compliance with both federal and state regulations is a physical impossibility,' or because the state law stands 'as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.''

The *Christian* cause of action and its monetary damages compliment the ERISA scheme and its assurance of quick administrative appeal from a denial. The administrative process can rectify an overzealous initial decision or ratify denial as part of company policy. Those denials that are deemed actionable will be identified and hopefully discontinued. Then both insured and insurer will have benefit of an administrative process as suggested by the ERISA statute but one that will be meaningful, giving the insured a quick and efficient way to challenge the denial of benefits and the company a safeguard against wrongful denials because of misunderstandings, miscommunications, and improper interpretations. The only way for ERISA to properly meet its stated goal is for companies to face the type of sanctions and

insureds to have the type of relief contemplated by a *Christian* cause of action. Not only is *Christian* not preempted by ERISA for ERISA to meet its stated goal, a *Christian* cause of action is essential.

In the case of *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 102 S.Ct. 3002, 73 L.Ed 2nd 647, Justice Rehnquist in his dissent first pointed out that from 1869 until 1944 insurance was completely under the governance of the states. After the U.S. Supreme Court held in *United States v. Southern-Eastern Underwriters Association*, 322 U.S. 533 (1944) that the business of insurance was part of interstate commerce, the Congress' quick response was the McCarran-Ferguson Act. The Court found that the purpose of the McCarran-Ferguson Act and the indispensable part of it was the contractual relationship between the insurer and the insured. That was the essence of 'the business of insurance.' Justice Rehnquist went on to state:

> "Central to this contractual relationship is the process of claims adjustment ' The determination of the actual payments to be made to the insured for losses covered by the insurance contract. **The key representation of the insurance company and the principal expectation of the policy holder is that prompt payment will be made when the event insured against actually occurs**. As one commentator has stated, 'Up until the time there is claim and payment is made the only tangible evidence of insurance is a piece of paper. In other words the real product of insurance is the claims proceeds. Selection of the prospect, qualifying him for coverage that suits his needs, delivery of a policy, collecting premiums for perhaps years, making changes in coverage to meet changing situations, all of these are but preambles to the one purpose for which the

> insured was secured, named to collect dollars if and when an unforeseen event takes place.' At 136. (Emphasis added).

Justice Rehnquist is exactly right. The sole business of insurance companies is to pay claims when a covered loss occurs. Beyond that all an insurance policy is is a piece of paper, a promise to perform should the need arise. It is the one thing that people purchase and hope they never have to use. It is precisely because of this that the Oklahoma Supreme Court determined that this contractual relationship should be treated differently than other contractual relationships where each party is trying to gain some form of commercial advantage.

Claims processing being the central piece of insurance business, it makes little sense to save all state insurance law except those that directly govern and most strongly *affect* the claims handling process. No law affects the claims handling process more than the implied covenant of good faith and fair dealing and its remedial and punitive provisions. It encourages the insurance company to handle the claim in the appropriate manner and compensates the insured when that does not happen. If the true test of whether or not an insurance law is saved from ERISA pre-emption is whether or not it affects the risk, then certainly the *Christian* cause of action passes that test with flying colors.

This Court stated in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 414 U.S. 645, 655 (1995) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947), the following:

> "We have never assumed lightly that Congress has degradated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant

> state law. Indeed, in cases . . . where federal law is said to bar state actions in fields of traditional state regulation, we have worked on the 'assumption that the historical police powers of the state were not to be superceded by the Federal Act unless that was the clear and manifest purpose of Congress'.'

That, of course, is the general rule of law that this Court will presume that traditional state regulatory law is not pre-empted by a Federal Act. In this instance, we have insurance law that is specifically saved from pre-emption. Yet unfortunately it appears that this Court did in fact assume that state insurance laws, otherwise saved from ERISA pre-emption, were nonetheless pre-empted when they provided remedies. The Court did so by predicting a fatal conflict between saved state insurance laws with remedies and ERISA. There is an illuminating Law Review article by Donald T. Bogan, *Protecting Patients' Rights Despite ERISA; Will the Supreme Court Allow States to Regulate Managed Care?* 74 Tul. L. Rev. 941 (2000), hereinafter Bogan, Protecting Patients' Rights) . This review supports the proposition that ERISA was never intended to comprehensively regulate non-pension employee benefits in any way, including by way of remedies, and that explains why the saving clause was enacted. As Mr. Bogan observed, the legislative history reveals that abuses in the pension industry lead to ERISA's enactment "to comprehensively reform the private pension industry. *Id* at 964, 967 N. 7. See also *Taggert Corp. v. Life and Health Benefits Admin., Inc.*, 612 F.2d 1208, 1211 (5th Cir. 1980). The majority of ERISA's substantive provisions, and this is reflected by its history, deal with funding, protection against insolvency, vesting, and protection of workers in case of insolvency - - these apply only to pension plans. Bogan, *Protecting Patients' Rights* at 974-975. Petitioner's counsel would add that the legislative history also

dealt with tax consequences and tax incentives to encourage savings by both employers and employees. Mr. Bogan demonstrates that "ERISA's legislative history provides no evidence that Congress seriously investigated, studied or debated any issue or concerns with non-pension employee benefit plans.' *Id.* at 927.

Mr. Bogan goes on to conclude, "[w]hile it is true that portions of ERISA apply to non-pension benefit plans, the statute certainly does not provide a complete and coordinated network of rules to govern non-pension employee benefits'. *Id.* at 973. *See also Id.* at 956-958. Bogan finally states that if the courts were to accept "[t]his new ERISA super-pre-emption doctrine [it would] create a glaring void in the field of welfare plan regulation because ERISA, with its detailed focus on pension issues, does not replace pre-empted state laws in the field of welfare benefit plans with any substantive federal regulation.' *Id.* at 986.

What laws regulate an insurance company under ERISA? If *Pegram v. Herdrich, supra*, is extended to all claims handling, then an insurance company is not exposed to any liability as a fiduciary. Thus, there appears to be no law within ERISA that regulates insurance companies. In his article, Mr. Bogan concluded by enacting the saving clause, Congress intended to confine pre-emption to pension plans "because ERISA provides a pervasive and coordinated regulatory scheme to govern pension plans and because the field of pension regulation does not have strong state-law roots.' *Id.* At 957. This conclusion seems most logical when you consider there is a dearth of ERISA substantive regulation of insurance. In essence, there are no insurance regulations in ERISA. There is a specific saving of state insurance law.

There is no real "conflict pre-emption' analysis in ERISA cases but there is a significant body in Medicare cases. The

lead case is *Ardary v. Aetna Health Plans of California, Inc.*, 98 F.3rd 496 (9th Cir. 1996). Certiorari was denied by the Supreme Court twice in this case. *Aetna Health Plans of California, Inc. v. Ardary,* 520 U.S. 1251, 117 S.Ct. 2408, 138 L.Ed. 2d 174 (1977) and *Inland Health Care Group v. Ardary,* 520 U.S. 1251, 117 S.Ct. 2407, 138 L./Ed. 2d 174 (1977).

The Ninth Circuit recognized that *Heckler v. Ringer*, 466 U.S. 602 (1984), declared that any benefit quest must be through the federal administrative process. The Court went on to state, "Because the states are independent sovereigns in our federal system, we have long presumed that Congress does not cavalierly pre-empt state-law causes of action. State law is pre-empted if the law actually conflicts with federal law.' At 501. The Court further went on to state that they "start with the assumption that the historic police powers of the states were not to be superseded by the federal act unless there was a clear and manifest purpose of Congress.' At 501 (Citation omitted both quotations). Finally, the Ninth Circuit stated,

> "[w]e find nothing in the legislature history to suggest that the Act was designed to abolish all state remedies which might exist against private Medicare providers for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA. Indeed, the 'legislative history of both the statute establishing the Medicare program and the 1972 Amendments thereto provide specific evidence of Congress' intent to foreclosure review only of 'amount determination' . . i.e. those 'quite minor matters,' 118 Cong. Rec. 33992 (1972) (Remarks of Sen. Bennett), remitted finally and exclusively to adjudication by private insurance carriers in a 'fair hearing.'' At 501 (Citations omitted)

Other cases holding similar state actions are not pre-

empted by the Medicare Act include *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F.Supp.2d 273 (E.D. N.Y. 1998), *Caputo v. United States Healthcare Sys.*, 1998 W.L. 80611 (E.D. Pa. 1998), *McCall v. Pacificare of California, Inc.*, 25 Cal. 4th 412, 21 P.3d 1189, 106 Cal.. Rptr. 271 (2001), *Plocica v. Nylcare of Texas, Inc.*, 43 F. Supp 2d 658 (N.D. Tex. 1999), *Green v. Aetna U.S. Healthcare, Inc.*, 2000 W.L. 1229226 (N.D. Cal. 2000), *Shands Teaching Hosp. and Clinics, Humans Medical Plan, Inc.*, 272 So.2d 341, Fla. App. Dist. 1999), and *Hofler v. Aetna U.S. Healthcare of Cal., Inc.*, 2002 W.L. 1467701 (9th Cir. 2002).

It seems that the reasoning in these cases apply equally well in the ERISA context.

CONCLUSION

For the reasons above, the Petition for Writ of Certiorari should be granted.

Respectfully Submitted,

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UNITED STATES COURT OF APPEALS

TENTH CIRCUIT

SALLEE A. CONOVER,

Plaintiff-Appellant,

v. No. 01-5172

AETNA US HEALTH CARE, INC.;
AETNA LIFE INSURANCE COMPANY,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Oklahoma
(D.C. No. 00-CV-559-B)

Joseph F. Clark, Jr., Tulsa, Oklahoma, for Plaintiff-Appellant

Mark D. Spencer (Henry D. Hoss and Amy T. Kranenburg) of McAfee & Taft, P. C., Oklahoma City, Oklahoma, for Defendants-Appellees.

Before O'BRIEN and McWILLIAMS, Circuit Judges, and BRORBY, Senior Circuit Judge.

BRORBY, Senior Circuit Judge.

Ms. Sallee Conover appeals from a district court decision holding her state law bad faith claim is preempted under the Employee Retirement Income Security Act. *See Conover v. Aetna U.S. Healthcare, Inc.*, 167 F. Supp.2d 1317 (N.D. Okla. 2001). Ms. Conover argues her claim is not preempted because the Act saves "any law of any State which regulates insurance." *See* 29 U.S.C. § 1144(b)(2)(A). We exercise jurisdiction pursuant to 28 U.S.C. § 1291 and affirm.

Ms. Conover was a participant in a long-term disability insurance plan through her employer. The plan was administered by Aetna US Healthcare. Ms. Conover was injured in a car accident and submitted a claim to Aetna for disability benefits. Aetna approved her claim and began making monthly benefit payments to her. After further investigation, however, Aetna determined Ms. Conover could perform the material duties of her occupation and suspended her benefits. Ms. Conover responded by filing this lawsuit in Tulsa County District Court, alleging intentional breach of contract and bad faith. The bad faith cause of action was based on Oklahoma state law. Aetna removed the case to the United States District Court for the Northern District of Oklahoma.

A few months later, Aetna reviewed additional information regarding Ms. Conover's claim for disability benefits and determined she remained eligible for the benefits. Aetna reinstated her benefits and paid all back benefits due. This rendered moot Ms. Conover's cause of action for intentional breach of contract. Around the same time, Aetna moved the district court for a determination regarding preemption under the Employee Retirement Income Security Act. In addressing the motion, the district court ruled the Act preempted Ms. Conover's bad faith cause of action. *See Conover*, 167 F. Supp.2d at 1318-21. The court subsequently entered final judgement for Aetna, and Ms. Conover appeals.

Ms. Conover argues her bad faith claim is not preempted

under the Employee Retirement Income Security Act.[2] We review this question de novo because it involves an issue of law. *See Woodworker's Supply, Inc. v. Principal Mut. Life Ins. Co.*, 170 F.3d 985, 989 (10th Cir. 1999).

The Employee Retirement Income Security Act preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The Act, however, saves from preemption state laws "regulat[ing] insurance." 29 U.S.C. § 1144(b)(2)(A). In determining whether a state law regulates insurance, we follow the two-step inquiry set forth by the Supreme Court in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). We first inquire whether, from a "common-sense view of the matter," the state la regulates insurance. *Id.* at 740; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987). We then test this result against three factors derived from case law interpreting the McCarran-Ferguson Act, 15 U.S.C. § 1012(a) & (b): "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743 (quotation marks and citation omitted); *Pilot Life*, 481 U.S. at 4849. All three McCarran-Ferguson factors need not be met in order for a state law to regulate insurance. *See Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, _____ , 122 S. Ct. 2151, 2163 (2002); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 373 (1999). Instead, these factors should be "weighed" and serve as "guideposts" in determining whether a state law regulates insurance. *Rush*

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[2] Ms. Conover also argues the Supreme Court's decision in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), permits us to award extra-contractual damages in Employee Retirement Income Security Act actions, including mental anguish and punitive damages. This argument is foreclosed by our decision in *Zimmerman v. Sloss Equipment, Inc.*, 72 F.3d 822, 827-829 (10th Cir. 1995).

Prudential, 122 S. Ct. at 2163; *Ward*, 526 U.S. at 373-74. If after applying this two-part inquiry, we are satisfied the state law regulates insurance, it is saved from preemption under the Act. See 29 U.S.C. § 1144(b)(2)(A). This does not, however, end our preemption analysis.

A state law otherwise regulating insurance within the meaning of § 514(b)(2)(A) may still be preempted if it allows plan participants and beneficiaries "to obtain remedies under state law that Congress rejected in [the Employee Retirement Income Security Act]." *Pilot Life*, 481 U.S. at 54, 57; *Rush Prudential*, 122 S. Ct. at 2165.[3] The Act sets forth "'six carefully integrated civil enforcement provisions.'" *Pilot Life*, 481 U.S. at 54 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)). See also 29 U.S.C. § 1132(a). Under these provisions, a plan participant or beneficiary may bring a civil action to recover benefits due, enforce rights, or clarify future benefits under the terms of the plan. See 29 U.S.C. § 1132(a)(l)(B). A plan participant or beneficiary may also bring an action to enforce provisions of the plan or Act, to enjoin or redress violations of the Act, or to

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[3] Ms. Conover suggests the Supreme Court impliedly overruled this portion of the *Pilot Life* decision in *Ward,* 526 U.S. at 376 n.7. We disagree for three reasons. First, the Supreme Court instructed us to avoid concluding its "more recent cases have, by implication, overruled an earlier precedent." *Agostini v. Felton*, 521 U.S. 203, 237 (1997). Rather, we "should follow the case which directly controls, leaving to [the Supreme] Court the prerogative of overruling its own decisions." *Id.* (quotation marks and citation omitted). Second, the Court in Ward noted but did not address the Solicitor General's argument that *Pilot Life* does not hold a state law regulating insurance is nevertheless preempted if it provides a state law cause of action or remedy. See *Ward*, 526 U.S. at 376 n.7. Third, the Supreme Court reaffirmed this portion of the *Pilot Life* decision in a later decision, stating a state law is preempted if it "allows plan participants to obtain remedies ... that Congress rejected in [the Employee Retirement Income Security Act]." *Rush Prudential*, 122 S. Ct. at 2165 (quoting *Pilot Life*, 481 U.S. at 54).

remove the fiduciary for breach of fiduciary duty. See 29 U.S.C. §§ 1132(a)(1)(A), 1132(a)(3), and 1109(a). In an action under these civil enforcement provisions, a court may, in its discretion, award attorney's fees and costs to either party. See 29 U.S.C. § 1132(g)(1). The Supreme Court held these civil enforcement provisions are "exclusive." *Pilot Life,* 481 U.S. at 52, 54. Therefore, if a state law "add[s] to the judicial remedies" available under the Act, the law is preempted. *Rush Prudential*, 122 S. Ct. at 2166.

It is undisputed Oklahoma's bad faith law falls within the Employee Retirement Income Security Act's language preempting state laws related to "any employee benefit plan." 29 U.S.C. § 1144(a). Oklahoma's bad faith law imposes on insurers "an implied duty to deal fairly and act in good faith with its insured." *Christian v. American Home Assurance Co.*, 577 P.2d 899, 904 (Okla. 1977). A "violation of this duty gives rise to an action in tort for which consequential and, in a proper case, punitive, damages may be sought." *Id.* Ms. Conover argues Oklahoma's bad faith law is saved from preemption under the Act because it "regulates insurance." See 29 U.S.C. § 1144(b)(2)(A). We disagree. This court addressed this issue in *Gaylor v. John Hancock Mutual Life Insurance Co.*, 112 F.3d 460, 466 (10th Cir. 1997), holding "Oklahoma's bad faith law does not sufficiently regulate insurance such that it falls within [the Act]'s saving clause." We are bound by this decision. See *Burlington N. & Santa Fe Ry. Co. v. Burton*, 270 F.3d 942, 947 (10th Cir. 2001), *cert denied*, 122 S. Ct. 2664 (2002).

Ms. Conover nonetheless suggests Oklahoma's bad faith law regulates insurance from a common-sense view because it "homes in on the insurance industry." See *Ward,* 526 U.S. at 359. We disagree. Even though Oklahoma's Supreme Court has associated its bad faith law with the insurance industry, "its origins are from general principles of tort and contract law." *Gaylor*, 112 F.3d at 466. Oklahoma's Supreme Court also recognized "'[t]here is an implied covenant of good faith and fair dealing in every contract.'" *Christian*, 577 P.2d at 904

(quoting *Gruenberg v. Aetna Ins. Co.*, 108 Cal. Rptr. 480, 484 (Cal. 1973)). Breach of any contract, and not just an insurance contract, may lead to liability in tort under Oklahoma law. See, e.g., *Beshara v. Southern Nat'l Bank*, 928 P.2d 280, 291 (Okla. 1996) ("When the factual situation warrants, an action for a breach of contract may also give rise to a tort action for a breach of the implied covenant of good faith and fair dealing."). Consequently, Oklahoma's bad faith law does not home in only on the insurance industry. See *Moffett v. Halliburton Energy Servs., Inc.*, 291 F.3d 1227, 1236 (10th Cir. 2002).

Ms. Conover also argues *Gaylor* is not controlling because it "rigidly applied" the McCarran-Ferguson factors, putting "undue emphasis on the [first McCarran-Ferguson] requirement that a law spread the risk among policy holders n order for it to qualify for the [Employee Retirement Income Security Act] saving clause." She claims a more "pliable approach" should be used in light of the subsequent Supreme Court decisions in *Rush Prudential* and *Ward*. The Court in these decisions clarified "the McCarran-Ferguson factors are considerations [to be] weighed in determining whether a state law regulates insurance"; a state law need not "satisfy all three McCarran-Ferguson factors in order to regulate insurance." *Ward*, 526 U.S. at 373 (quotation marks and citation omitted). See also *Rush Prudential*, 122 S. Ct. at 2163.

While we, of course, agree all three McCarran-Ferguson factors need not be satisfied for a state law to regulate insurance, *see Moffett*, 291 F.3d at 1236, we disagree with Ms. Conover's suggestion these later Supreme Court decisions undermine our holding in *Gaylor*. The *Gaylor* court did not put "undue emphasis" on any particular McCarran- Ferguson factor in reaching its decision. Instead, the court concluded Oklahoma's bad faith law did not meet the first and second McCarran-Ferguson factors, and the third factor was undermined because the law's origins were "from general principles of tort and contract law." *Gaylor*, 112 F.3d at 466. In contrast, the Supreme Court in both *Rush Prudential* and

Ward held the saving clause to apply, even though the first McCarran-Ferguson factor was arguably not met, only after finding the other two factors were "clearly" or "securely" satisfied. *Rush Prudential*, 122 S. Ct. at 2163; *Ward,* 526 U.S. at 364.[4]

Furthermore, the court in *Gaylor* concluded Oklahoma's bad faith law provided a cause of action excluded from the Employee Retirement Income Security Act's civil enforcement scheme and would therefore "pose an obstacle to the purposes and objectives of Congress." *Gaylor*, 112 F.3d at 466 (quoting *Pilot Life*, 481 U.S. at 52) .[5] Oklahoma's law allows plan participants to obtain "consequential and, in a proper case,

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[4]Even after the Supreme Court's decision in *Ward,* this court reaffirmed that a state law does not regulate insurance if it does not meet the first two McCarran-Ferguson factors, and the third factor is undermined because the law (although associated with the insurance industry) has its roots in tort and contract law. *See Moffett*, 291 F.3d at 1236-37.

[5]Ms. Conover disagrees, arguing Oklahoma's bad faith law does not conflict with the Employee Retirement Income Security Act's civil enforcement scheme. Ms. Conover claims "[t]he only way for [the Act] to properly meet its stated goal is for companies to face the type of sanctions and insureds to have the type of relief contemplated by [Oklahoma's bad faith law]." Once again, however, Ms. Conover's argument is foreclosed by our decision in Gaylor, 112 F.3d at 466. Ms. Conover's argument is also contrary to Supreme Court decisions holding the Act's civil enforcement scheme is exclusive. See Rush Prudential, 122 S. Ct. at 2165-66; Ingersoll-Rand, 498 U.S. at 144; Pilot Life, 481 U.S. at 52, 54; Russell, 473 U.S. at 146.

punitive, damages" for breach of good faith and fair dealing by an insurer. *Christian*, 577 P.2d at 904. Nowhere does the Employee Retirement Income Security Act allow consequential or punitive damages. Damages are limited to the recovery of "benefits due ... under the terms of the plan." See 29 U.S.C. § 1132(a)(1)(B). Oklahoma's bad faith law therefore "allows plan participants to obtain remedies ... that Congress rejected in the Act." *Rush Prudential*, 122 S. Ct. at 2165 (quoting *Pilot Life*, 481 U.S. at 54) (quotation marks omitted).

In sum, we conclude *Gaylor* still controls the resolution of this case. Oklahoma's bad faith law is not saved from preemption under Employee Retirement Income Security Act because it does not "regulate[] insurance." 29 U.S.C. § 1144(b)(2)(A). Oklahoma's bad faith law is therefore preempted because it "relate[s] to an employee benefit plan" and conflicts with the Employee Retirement Income Security Act's civil enforcement scheme. *See* 29 U.S.C. §§ 1144(a) and 1132(a). We AFFIRM the district court's decision.

11 UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

SALLEE A. CONOVER,

Plaintiff - Appellant,

v. No. 01-5172

AETNA US HEALTH CARE, INC.;
AETNA LIFE INSURANCE COMPANY,

Defendants - Appellees.

ORDER

Filed March 21, 2003

Before O'BRIEN, Circuit Judge, McWILLIAMS and BRORBY, Senior Circuit Judges.

Appellant's petition for rehearing is denied.

The petition for rehearing en bane was transmitted to all of the judges of the court who are in regular active service. As no member of the panel and no judge in regular active service on the court requested that the court be polled, that petition is also denied.

Entered for the Court
PATRICK FISHER, Clerk of Court

by: s/
Deputy Clerk

APPENDIX

29 U..S.C.A. § 1001

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18 - EMPLOYEE RETIREMENT
INCOME SECURITY PROGRAM
SUBCHAPTER I - PROTECTION OF
EMPLOYEE BENEFIT RIGHTS
SUBTITLE A - GENERAL PROVISIONS

§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce I and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect

to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension

plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

29 U.S.C.A. § 1132

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18 - EMPLOYEE RETIREMENT
INCOME SECURITY PROGRAM
SUBCHAPTER I - PROTECTION OF
EMPLOYEE BENEFIT RIGHTS
SUBTITLE B - REGULATORY PROVISIONS
PART 5 - ADMINISTRATION AND ENFORCEMENT

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action A civil action may be brought -

(1) by a participant or beneficiary -

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the he Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this

section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (1) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title[6] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has

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[6] So in original. Probably should be "subtitle".

not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if -

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 119lb(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable

to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 1021(f)(1) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material

requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to 8100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1.320b-14(c)(8) of Title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district

courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretionmay allow a reasonable attorney's ee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan -

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of -

(i) interest on the unpaid contributions,

or

(ii) liquidated damages provided for under the plan n an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph

(A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5)

of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of -

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this subtitle by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person, the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a

breach or violation described in paragraph (1) -

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that -

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

29 U.S.C.A. § 1144
UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18 - EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I - PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE B - REGULATORY PROVISIONS
PART 5 - ADMINISTRATION AND ENFORCEMENT

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State

purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section

(i) any State tax law relating to employee benefit plans, or

(fi) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section -

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully

insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides -

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully

insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action -

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only

to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.

(2)

Supreme Court, U.S.
FILED

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No. OFFICE OF THE CLERK

In The

Supreme Court of the United States

SALLEE A. CONOVER,

Petitioner,

v.

AETNA US HEALTHCARE, INC.,
and AETNA LIFE INSURANCE COMPANY

Respondents.

Supplemental Appendix to
Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Tenth Circuit

PETITION FOR A WRIT OF CERTIORARI

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA

FILED
AUG -2 2001
Phil Lombardi, Clerk
U.S. District Court

SALLEE A. CONOVER,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 00-C-559-B(J)
	)	
AETNA US HEALTHCARE, INC. and AETNA LIFE INSURANCE COMPANY,	)	Entered on Docket
	)	Date Sep 10 2001
Defendants.	)	

JUDGMENT

The Court, having ruled on defendants' motion for determination regarding ERISA pre-emption and jury trial issues as directed at case management conference, and being advised by the parties that nothing remains to be done except for the entry of judgment, hereby enters final judgment as follows:

Regarding Plaintiff's first cause of action in her petition (Intentional Breach of Contract), the parties have advised that defendants have reinstated plaintiff on disability and have paid her all disability benefits due and owing through the present, Plaintiff's first cause of action is

therefore MOOT.

Regarding Plaintiff's second cause of action in her petition (Breach of Good Faith and Fair Dealing by Insurance Carrier), the Court previously ruled in favor of defendants on their motion for determination ERISA pre-emption and jury trial issues as directed at case management conference, holding that ERISA pre-empts plaintiffs state law tort and contract claims, and does not permit a jury trial. The Court therefore enters judgment for DEFENDANTS in accordance with that ruling.

Final judgment is therefore entered herein accordingly.

Dated: 9-7-01

/s/ Thomas R. Brett
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA

FILED
AUG -2 2001
Phil Lombardi, Clerk
U.S. District Court

SALLEE A. CONOVER,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 00-C-559-B(J)
	)	
AETNA US HEALTHCARE, INC. and AETNA LIFE INSURANCE COMPANY,	)	
	)	
Defendants.	)	

ORDER

Comes on for decision Defendants' Motion For Determination Regarding Erisa Pre-Emption and Jury Trial Issues and the Court finds as follows:

Background[1]

Plaintiff, Sallee Conover ("Conover"), was a participant in a long-term disability insurance plan ("Plan")

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[1]"The background is substantially taken from Defendants Motion For Specialized Case Management, prepared without input by Plaintiff, and is included only to provide a general statement of the dispute. Some facts were added from Plaintiff's brief in opposition to Defendant's Motion for Determination Regarding Erisa issues.

through her employer, Harcourt General, Inc. All premiums were paid by Conover. The Plan was administered by Aetna US Healthcare and provided supplemental benefits for total disability for a prescribed period of time under the terms and conditions of the Plan. The Plan required certification of disability in lieu of suspension of benefits and advised participants that rights and benefits under the Plan were regulated under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§1001-1468.

Conover was reportedly involved in a car accident on November 12, 1997. She applied for benefits under the Plan and was certified as disabled on July 13, 1998. Under the terms of the Plan, Conover became eligible for disability benefits on January 11, 1999, and benefits were paid to her thereafter on a monthly basis. In May, 1999, Conover underwent a Functional Capacity Evaluation as part of her continuing certification process. The evaluation concluded that she could perform the material duties of her occupation with her employer. Therefore, she was no longer eligible for benefits. Plaintiff was notified of the suspension of her benefits on August 6, 1999. This lawsuit was filed in Tulsa County District Court and subsequently removed to this Court

Issues Presented

Defendants filed a motion for specialized case management conference under the administrative review framework of ERISA. At the regularly scheduled case management conference which followed, the Court addressed various issues regarding ERISA'S applicability to the case at bar and the Court ordered briefing on two issues: whether ERISA pre-empts Plaintiff's state law claims, and whether a jury trial is permitted.

The pertinent issue in determining whether Plaintiff's state law claims are pre-empted is whether the United States Supreme Court in *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999) alters the binding precedent of *Gaylor v. John Hancock Mutual Life Ins. Co.*, 112 F.3d 460 (10th Cir. 1997). In *Gaylor*, the Tenth Circuit held that "Oklahoma's bad faith law does not sufficiently regulate insurance such that it falls within ERISA's saving clause,"[2] and therefore is preempted by ERISA. *Id.* at 466. In so holding, the circuit court applied the test set forth in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987), which includes an analysis of the three McCarran-Ferguson factors:

> ... whether the state law (1) has the effect of transferring or spreading a policyholder's risk; (2) is an integral part of the policy relationship between the insurer and the insured; and (3) is limited to entities within the insurance industry.

Id. at 465. The Tenth Circuit determined that while Oklahoma's bad faith law is "specifically directed at the insurance industry," it is not an integral part of the policy relationship between the insurer and insured, does not effect a change in the risk borne by either party and, like Mississippi's bad faith law in *Pilot Life*, has "its origins ... [in) general

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[2] The saving clause states in pertinent part:
[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . .
29 U.S.C. § 1144(b)(2)(A)

principles of tort and contract law."[3] *Id.* Guided by *Gaylor,* this Court has previously held that ERISA preempts the Oklahoma common law claim recognized in *Christian v. American Home Assurance Co.*, 577 P,2d 899 (Okla. 1977), as the claim does not fall within the ERISA saving clause. See e.g. *Richard Lee Smith v. Sun Life Assurance Co. of Canada*, 98-CV-4 I 8-B(E) (removal proper in non-diversity case which states only state law claims of breach of contract and bad faith denial of long-term disability benefits under insurance policy due to ERISA preemption).

In *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F.Supp.2d 1202 (N.D.Okla. 1999), Judge Holmes of this Court held otherwise and effectively determined *UNUM* supercedes or alters *Gaylor*'s holding that Oklahoma's bad faith law is preempted by ERISA. *Id.* at 1214-15. In *UNUM*, the Supreme Court expressly rejected the proposition that a state law must satisfy all three McCarran-Ferguson factors to fall within the saving clause, characterizing the factors as "considerations [to be] weighed," none of which is determinative in itself[4]

---

[3] The Mississippi bad faith law at issue in *Pilot Life,* however, was applicable to any breach of contract, while the *Christian* tort is limited to insurance contracts.

[4]The state law at issue in *UNUM* was California's common taw notice-prejudice rule which requires the insurer to prove it suffered actual prejudice in its defense of an insured's failure to give timely notice of a claim. As noted by the *UNUM* Court, "[c]ornmon-law rules developed by decisions of state courts are "State law" under ERISA." *UNUM*, 526 U.S. at 367 n. I; see also 29 U.S.C. §1144(c)(1) ("The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of

UNUM, 526 U. S. at 373 (quoting *Pilot Life*, 481 U.S. at 49). The *UNUM* Court reiterated the test to determine whether a state law falls within the saving clause as set forth in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985):

> *Metropolitan Life* asked first whether the law there in question "fit a commonsense understanding of insurance regulation," ... and then looked to the McCarran-Ferguson factors as checking points or "guideposts, not separate essential elements . . . that must each be satisfied" to save the State's law.

UNUM, 526 U.S. at 374 (citations omitted). Applying this test, the *UNUM* Court concluded California's notice-prejudice rule is a state law that regulates insurance. Although the rule does not meet the first McCarran-Ferguson factor of transferring or spreading a policyholder's risk, the Supreme Court concluded it is, as a matter of common sense, a rule that regulates insurance, serves as an integral part of the policy relationship between the insurer and insured, and is limited to the insurance industry, thus meeting two of the three McCarran-Ferguson factors, and "verifying the common-sense view " *Id.* at 374-75. Applying this same analysis to a *Christian tort*, Judge Holmes in *Lewis* held the Oklahoma law, like the notice-prejudice rule in *UNUM*, "regulates insurance from a common sense view of the matter," and meets the second and third McCarran-Ferguson factors. Therefore, contrary to the holding in *Gaylor*, Judge Holmes concluded Oklahoma's bad faith rule is a state law that regulates insurance. *Lewis*, 78 F.Supp.2d at 1214-15.

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any State.").

While the Tenth Circuit in *Gaylor* applied a less "supple" test in its analysis of Oklahoma's bad faith rule than that applied in *UNUM* to California's notice-prejudice rule,[5] the Court is not persuaded the *Gaylor* test is enough at odds with *UNUM* to free the Court from *Gaylor*'s dictates. The Tenth Circuit in *Gaylor* concluded Oklahoma's bad faith rule did not "regulate insurance" based on the following analysis:

> Our application of the three-part test in *Pilot Life,* as well as previous cases applying the test to similar state laws, indicates that Oklahoma's bad faith law does not sufficiently regulate insurance such that it falls within ERISA's saving clause. Oklahoma's bad faith law does not regulate the spreading of policyholder risk... . A law which defines the manner in which insurance claims should be processed "declares only that, whatever terms have been agreed upon in the insurance contract, a breach of that contract may in certain circumstances allow the policyholder to obtain [consequential and] punitive damages. . Such a law thus does not effect a change in the risk borne by insurers and the insured, because it does not affect the substantive terms of the insurance contract. On the other hand, a law mandating that a certain disease be covered under health insurance contracts would effect a spread of

---

[5]See *UNUM*, 526 U.S. at 373 (rejecting the assertion that a state regulation must satisfy all three McCarran-Ferguson factors to fall within ERISA's saving clause as less "supple" than Supreme Court precedent requires).

risk, both from insureds to insurers and among the insureds themselves.... For substantially the same reasons, we hold that Oklahoma's bad faith law also does not satisfy the second prong of *Pilot Life*.... Finally, although Oklahoma's bad faith law is specifically directed at the insurance industry, we note that, Eke the bad faith law in *Pilot Life*, its origins are from general principles of tort and contract law....

Finally, we note that in holding that Mississippi's bad faith law was not saved, the *Pilot Life* court concluded that the civil enforcement provisions of ERISA §1132(a) were intended to be the "exclusive vehicle for actions by ERISA plan participants and beneficiaries asserting improper processing of a claim for benefits".... As Ms. Gaylor notes in her own brief, Oklahoma's bad faith law is designed to provide causes of action for the improper processing of a claim for benefits.... Thus, Ms. Gaylor's claim under Oklahoma's bad faith law is a claim within the scope of ERISA §1132(a) and "would pose an obstacle to the purposes and objectives of Congress." [6]

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[6]The Court questions the relevance of a conflict with the civil enforcement provisions of ERISA in a state-law exemption analysis. Under ERISA, a state law which regulates insurance is expressly exempted from preemption. ERISA does not dictate a state law which regulates insurance is exempt unless it provides a state law cause of action or remedy. See UNUM, 526 U.S. at 377 n. 7 (discussing but not

Gaylor, 112 F.3d at 466 (citations omitted). Thus, from the Court's reading of *Gaylor*, Oklahoma's bad faith rule does not meet the first and second McCarran-Ferguson factors, and the third is undermined by the rule's "origins" in general principles of tort and contract law. Judge Holmes, contrarily, concluded the second and third factors, together with a common sense understanding that the rule regulates insurance, weigh in favor of inclusion of a Christian tort within the saving clause. Although *UNUM* certainly emphasizes the McCarran-Ferguson factors are "guideposts" and not required elements of inclusion within the ambit of ERISA's saving clause, the Court is not convinced a post-*UNUM* decision by the Tenth Circuit would invalidate *Gaylor*. Regardless of whether the Court agrees with the analysis in *Lewis*, the Court is bound to follow *Gaylor*, until the issue is revisited by the Tenth Circuit or the United States Supreme Court. See *Campbell v. Guarantee Life Ins. Co.*, 99-279-S (E.D. Okla. 1999)(dismissing *Christian* tort claim, concluding "[t]he Tenth Circuit's application of the *Pilot Life* framework in *Gaylor* in the context of Oklahoma's bad faith law remains unaffected by *UNUM*"); *Bryant v. American Medical Security et al.*, CIV-00- 144-R (W D, Okla. 2000)(the court is bound by *Gaylor*'s holding that "Oklahoma's bad faith law does not sufficiently `regulate insurance' to fall within ERISA's savings clause"); but see *Hill v. Blue Cross Blue Shield of Alabama*, 117 F.Supp.2d 1209 (N D. Ala. 2000)(remanding case which alleged bad faith breach of insurance policy , holding that Alabama's state law tort claim of bad faith is exempt from ERISA preemption under the "saving clause" according to *UNUM*).

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deciding this issue).

The Tenth Circuit has also foreclosed a federal common law remedy of extracontractual damages for a denial of benefits under an ERISA plan.[7] *Zimmerman v. Sloss Equipment, Inc.*, 72 F.3d 822 (10th Cir. 1995). The plaintiff in *Zimmerman* had argued the Supreme Court decision in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) permits the courts to fashion remedies beyond the payment of unpaid benefits. Id. at 827-28 (quoting *Ingersoll-Rand*, 498 U. S. at 145 ("Not only is §502(a) the exclusive remedy for vindicating §510-protected rights, but there is no basis in §502(a)'s language for limiting ERISA actions to only those which seek `pension benefits.' It is clear that the relief requested here is well within the power of federal courts to provide.")). In rejecting that argument, the *Zimmerman* court concluded:

> This interpretation of *Ingersoll-Rand* is foreclosed by prior decisions of this court. We have previously held that punitive damages are not available in an ERISA action. *Sage v. Automation, Inc. Pension Plan & Trust*, 845 F.2d 885, 888 n.2 (10th Cir 1988). We have also held that nothing in section 502(a)(1)(B)

---

[7] Section 502 provides the civil remedies for violation of ERISA, 29 U.S.C. §1132 . Under subsection 502(a)(1)(B), a participant may bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. §1132(a)(1)(B). Subsection 502(a)(3)(B) authorizes civil actions "to obtain other appropriate equitable relief (i) to redress ... violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. §1132(a)(3)(B).

> supports damages beyond that section's language authorizing recovery of "benefits due. . . under the terms of the plan." *See Alexander v. Anheuser-Busch Companies, Inc.*, 990 F.2d 536, 539 (10th Cir. 1993). .. Moreover, we have ruled that compensatory damages are not available under section 502(a)(3)(B). *Lafoy v HMO Colorado*, 988 F.2d 97,99-101 (10'" Cir. 1993)... We held in *Lafoy* that although "allowing extra-contractual relief may be supportable on grounds of policy and justice, . . . the plain history of the statute, the legislative history, and the majority's ruling in Russell [*Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985)] [8] counsel otherwise."

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[8] In *Russell*, the Supreme Court explained the remedies available in §502(a) of ERISA:

> The six carefully integrated civil enforcement provisions found in §502(a) as finally enacted, however, provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a "comprehensive and reticulated statute."
>
> . . .
>
> We are reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA.. . "{W]here a statute expressly provides a particular remedy or remedies, a court must be chary of reading others into it."

Russell, 473 U.S. at 146-48 (citations and footnotes omitted).

Id. at 828 (citation omitted); see also *Nero v. Industrial Molding Corp.*, 167 F.3d 921 (5th, Cir. 1999) (out-of-pocket expenses not recoverable under §502(a)(3)); *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir.), cert. denied, 506 U.S. 818 (1992) (extracontractual damages unavailable under §502(a)(1)(B)). Based on Tenth Circuit precedent, therefore, the Court is precluded from creating a federal common law remedy for extracontractual damages under ERISA.

The Court further concludes Plaintiff is not entitled to a jury trial. See *Adams v. Cyprus Amax Minerals Co.*, 149 F.3d 1156 (10'" Cir. 1998)("[T]he recovery of benefits is better characterized as equitable/restitutionary versus legal/compensatory relief' and therefore, the Seventh Amendment does not entitled plaintiff to a jury trial.). In view of the above, the Court grants Defendant's Motion for Specialized Case Management and sets a new scheduling conference for the 7th day of Sept., 2001, at 1:30 p.m.

IT IS SO ORDERED, this 2nd day of August, 2001.

/s/ Thomas R. Brett
THOMAS R BRETT
UNITED STATES DISTRICT JUDGE

Supreme Court, U.S.
FILED
JAN 26 2003
OFFICE OF THE CLERK

No. 02-1864

IN THE

Supreme Court of the United States

SALLEE A. CONOVER,

Petitioner,

v.

AETNA INC., F/K/A AETNA U.S. HEALTHCARE INC.; AETNA LIFE INSURANCE CO.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempts tort claims, asserted under Oklahoma common law, for bad-faith denial of benefits under an ERISA plan.

PARTIES TO THE PROCEEDINGS

The caption contains the names of all of the parties.

Respondent Aetna Inc. is the successor to Aetna U.S. Healthcare Inc., which was a defendant-appellee in the court below.

RULE 29.6 STATEMENT

The parent company of respondent Aetna Life Insurance Co. is respondent Aetna Inc., a publicly traded company.

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§ 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) ..... *passim*

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Court Documents

Brief for the United States as Amicus Curiae, *United States Healthcare Systems of Pennsylvania, Inc. v. Pennsylvania Hospital Insurance Co.*, No. 98-1836 (filed Dec. 17, 1999) 19

Brief for Respondent Aetna Health Inc., *Roark v. Humana, Inc.*, No. 02-1826 (filed July 7, 2003) 20

BRIEF FOR RESPONDENTS IN OPPOSITION

Respondents Aetna Inc. (as successor to Aetna U.S. Healthcare Inc.) and Aetna Life Insurance Co. respectfully request that the petition for a writ of certiorari be denied.

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-8a) is reported at 320 F.3d 1076 (10th Cir. 2003). The order of the district court concluding that petitioner's common law tort claim is preempted by ERISA (Supp. Pet. App. 29a-39a) is reported at 167 F. Supp. 2d 1317 (N.D. Okla. 2001). The order of the district court entering judgment for respondents (Supp. Pet. App. 27a-28a) is not reported.

JURISDICTION

The judgment below was entered on February 20, 2003. Pet. App. 1a. A timely petition for rehearing was denied on March 21, 2003. *Id.* at 9a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATEMENT OF THE CASE

1. Through her employer, petitioner participated in an employee benefit plan that included long-term disability insurance coverage. Pet. App. 2a. Under the terms of the plan, beneficiaries who became totally disabled could obtain supplemental benefits for a prescribed period of time, subject to the condition that benefits would be suspended absent periodic certification of continued disability. Supp. Pet. App. 30a. As the plan documents stated, the plan was covered by and regulated under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* Respondent Aetna Life Insurance Co. ("ALIC") administered and insured the long-term disability plan. Supp. Pet. App. 30a.

After she was injured in a car accident, petitioner submitted a claim for long-term disability benefits under the plan. Petitioner was certified as disabled and thereafter began to receive monthly disability benefits. Pet. App. 2a. Several months later, petitioner's regularly scheduled Functional Capacity Evaluation determined that she was no longer disabled from performing the material duties of her job. Based on the evaluation, ALIC suspended petitioner's benefits in accordance with the terms of the plan. Supp. Pet. App. 30a. As detailed below, ALIC subsequently resumed the benefit payments and paid the suspended benefits once new information led it to conclude that petitioner was still disabled.

2. After her benefits were suspended, petitioner filed suit against Aetna U.S. Healthcare Inc. in Oklahoma state court. Her petition asserted causes of action for intentional breach of contract and for bad faith under Oklahoma common law. Pet. App. 2a; *see* App., *infra*, 9a-11a. Aetna U.S. Healthcare removed the action to the United States District Court for the Northern District of Oklahoma on grounds of diversity of citizenship and of federal question jurisdiction based on the "complete preemption" doctrine. Pet. App. 2a; *see* App., *infra*, 1a-4a. Under that doctrine, a claim that is "completely preempted" by the exclusive remedial scheme set out in ERISA § 502(a), 29 U.S.C. § 1132(a), presents a federal question and is subject to removal on that basis, even if on its face it purports to assert only state-law claims. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 67 (1987). Petitioner did not contest the removal or move to remand.[1]

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[1] After removal, because of the possibility that Aetna U.S. Healthcare was not the proper defendant in an action pertaining solely to disability insurance benefits, the parties stipulated to the addition of ALIC as a defendant, although neither Aetna U.S. Healthcare nor ALIC conceded liability.

As the litigation proceeded in district court, petitioner presented ALIC with further information about her medical condition. ALIC determined, based on this previously unavailable information, that petitioner remained eligible for total disability benefits. It accordingly reinstated her benefits retroactively and paid her a lump sum covering the period of the suspension. Pet. App. 2a. ALIC's complete satisfaction of the terms of the plan mooted petitioner's claim for breach of contract. Supp. Pet. App. 27a-28a.

ALIC asserted that petitioner's sole remaining claim, for bad-faith denial of benefits, was preempted by ERISA. Adhering to circuit precedent, the district court agreed.

In *Gaylor v. John Hancock Mutual Life Insurance Co.*, 112 F.3d 460 (10th Cir. 1997), the Tenth Circuit had considered the identical Oklahoma common law tort and held that *either* of two distinct forms of ERISA preemption was sufficient to bar the plaintiff's action. The Tenth Circuit held that a tort claim under Oklahoma law alleging bad faith in the administration of benefits was preempted by ERISA § 514(a), 29 U.S.C. § 1144(a), which supersedes any state law that "relate[s] to" an ERISA plan. *Gaylor*, 112 F.3d at 465-66. In the alternative, the *Gaylor* court held that such a state tort claim was completely preempted by ERISA § 502(a), 29 U.S.C. § 1132(a). That section provides the exclusive remedies for violations of ERISA and, as this Court first established in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), precludes a State from supplementing those remedies. *Gaylor*, 112 F.3d at 466 (citing *Pilot Life*, 481 U.S. at 52). The district court in this case followed *Gaylor* in both respects.

a. Turning first to the Section 514 issue, the district court explained that because there was no serious dispute that the state tort claim "relate[d] to" the ERISA plan, the only real question was whether the bad-faith cause of action was saved from preemption under an exception to Section 514's

broad rule. *See* Supp. Pet. App. 31a & n.2. Petitioner argued that the cause of action survived pursuant to the Insurance Saving Clause, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), which saves from preemption any state law that "regulates insurance." Supp. Pet. App. 31a. The Tenth Circuit had rejected just that contention in *Gaylor*, holding that the Oklahoma bad-faith tort was not an insurance regulation within the meaning of the saving clause. *Id.* (citing *Gaylor*, 112 F.3d at 466). The district court accordingly held that the bad-faith cause of action was preempted by Section 514 and was not preserved by the saving clause. *See id.* at 31a, 36a.

b. The district court also followed *Gaylor*'s discussion of the complete-preemption issue under Section 502(a) of ERISA. The *Gaylor* court had stated that Oklahoma's bad-faith law was completely preempted because it "is designed to provide causes of action for the improper processing of a claim for benefits," is thus "within the scope of ERISA § [502(a)]," and if allowed to proceed "'would pose an obstacle to the purposes and objectives of Congress'" in making § 502(a) exclusive. *Gaylor*, 112 F.3d at 466 (quoting *Pilot Life*, 481 U.S. at 52). The district court adhered to this holding, noting in a footnote that the conflict with ERISA's civil enforcement provision was distinct from the saving-clause analysis under Section 514. *See* Supp. Pet. App. 35a & n.6.

c. Since petitioner's breach of contract claim had been mooted when ALIC paid her all the benefits she was due, and having held the bad-faith claim preempted, the district court entered judgment for ALIC. Supp. Pet. App. 27a-28a.

3. The Tenth Circuit affirmed, agreeing with the district court that petitioner's bad-faith claim was preempted by both Section 514(a) and Section 502(a) of ERISA.

a. In the Tenth Circuit's view, this case required only a straightforward application of this Court's decisions, chiefly *Pilot Life*, and its own precedent in *Gaylor*. Pet. App. 3a, 5a.

This Court held in *Pilot Life* that a Mississippi tort remedy for denial of insurance benefits in bad faith was preempted by Section 514(a) and was not preserved by Section 514(b)(2)(A)'s Insurance Saving Clause. The *Gaylor* decision had applied those principles, concluded that the Oklahoma bad-faith tort was indistinguishable from the Mississippi cause of action at issue in *Pilot Life*, and accordingly held that the Oklahoma cause of action was similarly preempted. The Tenth Circuit found *Gaylor* controlling and reaffirmed its reasoning: Oklahoma's bad-faith law is not saved as an insurance regulation because "'its origins are from general principles of tort and contract law'" and because "[b]reach of any contract, not just an insurance contract, may lead to liability in tort under Oklahoma law." Pet. App. 5a-6a (quoting *Gaylor*, 112 F.3d at 466).

The Tenth Circuit also rejected the contention that intervening decisions of this Court required it to depart from *Gaylor*. The mode of analysis set out in this Court's cases, the court of appeals held, had not changed in substance: "We first inquire whether, from a 'common-sense view of the matter,' the state law regulates insurance. We then test this result against three factors derived from case law interpreting the McCarran-Ferguson Act . . . ." Pet. App. 3a (quoting *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985)) (citations omitted). The Tenth Circuit observed that even if this Court had since changed the relative weight to be accorded the various McCarran-Ferguson factors, that development did nothing to undermine *Gaylor*'s core holding, because the *Gaylor* court had concluded that the Oklahoma bad-faith tort satisfied *none* of those factors. *Id.* at 6a.

b. The Tenth Circuit then turned to ERISA § 502(a)'s complete preemption of state-law remedies that impermissibly supplement the forms of relief specified in the federal statute. *See Pilot Life*, 481 U.S. at 52-53 (holding that the remedies provided by Congress in Section 502(a) are exclu-

sive). The court reasoned that Oklahoma permits bad-faith claimants to recover punitive and consequential damages, whereas ERISA does not allow such awards and limits monetary relief to the recovery of benefits due. Pet. App. 7a-8a (citing ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)). Thus, as it had in *Gaylor*, the court of appeals concluded that the bad-faith action would provide a supplemental remedy, in contravention of the congressional intent that Section 502(a) remain the exclusive source of remedies. The court also noted that since *Gaylor* was decided, this Court had reiterated once again that ERISA's remedial provision is exclusive. *See id.* at 7a n.5, 8a (citing *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 377-78 (2002)).

c. Because both Section 514 and Section 502(a) precluded petitioner from pursuing her bad-faith tort claim, the court of appeals affirmed the judgment of the district court. Pet. App. 8a. Petitioner unsuccessfully sought rehearing and rehearing en banc. *Id.* at 9a.

ARGUMENT

Each of the two independent grounds on which the Tenth Circuit rested its preemption decision in this case is sound and compelled by this Court's precedents. Indeed, both of those grounds represent direct application of *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987). This Court held in *Pilot Life*, just as the Tenth Circuit held in *Gaylor* and in this case, that the common law tort of bad faith is preempted by Section 514(a) of ERISA, because it is not a "saved" regulation of insurance, and is also completely preempted by Section 502(a), because it provides remedies in addition to those specified in that provision. Thus, on its merits, the Tenth Circuit's decision does not warrant review.

Although some courts other than the Tenth Circuit have misread this Court's precedents with respect to both Section 502(a) and Section 514(a), creating tension with the larger

body of cases that faithfully follow those precedents, this case does not present a suitable vehicle to resolve these conflicts. Indeed, the petition does not even adequately address any conflict. Instead, the petition focuses primarily on the question whether the tort of "bad faith" is preempted—a question that the courts of appeals have unanimously answered in the affirmative—and it places particular emphasis on parochial issues relating to the tort of bad faith as it has developed in Oklahoma. *See* Pet. 13-23. Those issues do not warrant this Court's review.

I. The Court Of Appeals Correctly Applied This Court's Precedents In Holding That Petitioner's Claims Are Preempted Under Sections 514 And 502 Of ERISA

This Court has held on a number of occasions that state tort claims challenging the administration of benefits are preempted by Section 514(a); are not saved from preemption by Section 514(b)(2)(A); and are also independently, and completely, preempted by Section 502(a). Indeed, this Court has unanimously concluded that a state tort claim for bad faith, virtually identical to the one petitioner sought to bring, is preempted by both Sections 502(a) and 514 of ERISA. *See Pilot Life*, 481 U.S. at 49-50, 52-55, 56-57. The court of appeals was not free to depart from those precedents, nor should its entirely correct application of settled preemption principles be disturbed.

A. Petitioner's Contention That The Tenth Circuit Misconstrued Oklahoma Tort Law Does Not Warrant Review

For the most part, the petition simply rehearses policy arguments that this Court has already rejected in *Pilot Life* and its progeny, and that are more properly addressed to Congress. Petitioner's primary legal contention is that review by this Court is warranted because the Tenth Circuit's

interpretation of Oklahoma tort law was erroneous. Pet. 13-23.

The Tenth Circuit showed ample support in both this Court's cases and the law of Oklahoma for its conclusion that Oklahoma's bad-faith tort derives from general common law principles and therefore is not saved as a regulation of insurance. *Compare Pilot Life*, 481 U.S. at 50 ("Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law."), *with* Pet. App. 5a-6a ("Even though Oklahoma's Supreme Court has associated its bad faith law with the insurance industry, 'its origins are from general principles of tort and contract law.' . . . Breach of any contract, and not just an insurance contract, may lead to liability in tort under Oklahoma law." (quoting *Gaylor*, 112 F.3d at 466)). Even if *Pilot Life*'s holding were a narrow one, confined to the specific type of tort at issue—which it was not[2]—it would still control this case; the court below found nothing in Oklahoma's common law of tort and contract to distinguish the cause of action petitioner asserted

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[2] *See, e.g.*, *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987) (stating, in a case decided the same day as *Pilot Life*, that the plaintiff's Michigan tort claims were "pre-empted by § 514(a) and [were] not saved by § 514(b)(2)(A)," because they were "based upon common law of general application that is not a law regulating insurance"); *see also Taylor v. Gen. Motors Corp.*, 763 F.2d 216, 217 (6th Cir. 1985) (noting that the tort claims at issue in *Taylor* were for "wrongful termination of disability benefits" and "retaliatory discharge"), *rev'd sub nom. Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

from the similar cause of action held preempted in *Pilot Life*.[3]

Petitioner's exegesis of Oklahoma's bad-faith tort and its common law origins simply does not reveal an error in the Tenth Circuit's judgment that warrants this Court's intervention. The Tenth Circuit faithfully applied this Court's precedents, engaged in the correct mode of analysis, and arrived at a result that is entirely consonant with those reached in other cases presenting identical tort claims. Indeed, the Tenth Circuit—which regularly deals with Oklahoma law and whose analysis thereof is "entitled to respect," *County Court v. Allen*, 442 U.S. 140, 153-54 (1979)[4]—has now *twice* reached

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[3] Indeed, the result the court below reached in this case is entirely consonant with its analysis of other bad-faith torts in the other states within that circuit, as well as the holdings of other circuits. *See, e.g., Moffett v. Halliburton Energy Servs., Inc.*, 291 F.3d 1227, 1237 (10th Cir. 2002) (holding that Wyoming's bad-faith cause of action is preempted by Sections 514(a) and 502(a)); *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453, 456 (10th Cir. 1989) (reaching the same conclusion with respect to Colorado's bad-faith cause of action); *accord, e.g., Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576, 582 (6th Cir. 2002) (Indiana); *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442, 446-47 (8th Cir. 2002) (Iowa); *Gilbert v. Alta Health & Life Ins. Co.*, 276 F.3d 1292, 1301 (11th Cir. 2001) (Alabama); *Pryzbowski v. U.S. Healthcare Inc.*, 245 F.3d 266, 270, 273-75 (3d Cir. 2001) (New Jersey); *Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003, 1008 (9th Cir. 1998) (Washington); *Tingey v. Pixley-Richards W., Inc.*, 953 F.2d 1124, 1129, 1133 (9th Cir. 1992) (Arizona).

[4] Although interpretations of state law are re-examined de novo on plenary review, *Salve Regina Coll. v. Russell*, 499 U.S. 225, 239-40 (1991), this Court in the sound exercise of its certiorari jurisdiction generally leaves purely parochial questions of state law to the regional courts of appeals, *cf.* SUP. CT. R. 10. *See gen-*

the same conclusion with respect to the same bad-faith cause of action, rejecting at each instance the contention that some unique aspect of Oklahoma common law justifies departing from *Pilot Life* and the multitude of other cases holding state bad-faith tort remedies preempted by ERISA.

Moreover, petitioner does not assert—nor could she—that peculiarities of Oklahoma law distinguish her bad-faith claim from Dedeaux's Mississippi claim for purposes of preemption *under Section 502(a)*.[5] Tort damages based on the administration of benefits are not available under ERISA § 502(a) and are therefore preempted by that section. Just as with the Mississippi bad-faith tort that was at issue in *Pilot Life*, the Oklahoma cause of action would disrupt the exclusivity of Section 502(a) by making available punitive and consequential damages when Congress specifically rejected those remedies. *See* Pet. App. 7a-8a; *Pilot Life*, 481 U.S. at 50, 53-54; *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985). It is therefore completely preempted by Section

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erally UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 368 (1999) (stating that this Court "do[es] not normally disturb an appeals court's judgment on an issue so heavily dependent on an analysis of state law"); *Bishop v. Wood*, 426 U.S. 341, 346 (1976) ("[T]his Court has accepted the interpretation of state law in which the District Court and the Court of Appeals have concurred even if an examination of the state-law issue without such guidance might have justified a different conclusion.").

[5] Petitioner argued to the court of appeals that the bad-faith tort does not conflict with the civil enforcement scheme because even though the supplemental tort remedy she seeks is not included in Section 502(a), it is nonetheless somehow essential to ERISA's statutory purpose. As the court of appeals noted, this argument is contrary to all of this Court's cases holding Section 502(a) to be exclusive. *See* Pet. App. 7a n.5.

502(a) irrespective of the branch of Oklahoma common law in which it originated.

B. The Tenth Circuit's Insurance Saving Clause Analysis Is Entirely Consistent With The *Kentucky Health Plans* Decision

The Tenth Circuit issued its decision before this Court's recent opinion in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471 (2003), in which the Court reformulated its prior saving-clause case law into a more straightforward two-part test:

> [F]or a state law to be deemed a "law . . . which regulates insurance" under § 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

Kentucky Health Plans, 123 S. Ct. at 1479 (citations omitted). Although the Court had in the past accorded some significance—albeit less than dispositive—to other factors that were originally developed in cases applying the McCarran-Ferguson Act, the Court disclaimed future reliance on those factors in ERISA saving-clause analysis. *Id.* at 1478-79.

The court of appeals' decision was entirely consistent with the reformulated saving-clause analysis that the *Kentucky Health Plans* Court announced, because it was based on factors that have been central to the saving-clause analysis since *Pilot Life* and that this Court reaffirmed in *Kentucky Health Plans*. Petitioner's contention that the Tenth Circuit's application of these settled principles requires further reexamination, *see* Pet. 2, 21-23, is simply incorrect.

Neither of the elements of the two-part test announced in *Kentucky Health Plans* was new, and the Tenth Circuit con-

sidered both in rejecting petitioner's saving-clause claim That the first element was not a new addition to the test is clear from the Court's citation to an unbroken string of decisions from *Pilot Life* through the more recent *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002). *Kentucky Health Plans*, 123 S. Ct. at 1475, 1479 (citing *Rush Prudential*, 536 U.S. at 366; *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 368 (1999); *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990); and *Pilot Life*, 481 U.S. at 50). And applying those decisions, the Tenth Circuit has repeatedly found that the Oklahoma bad-faith tort is a general principle of common law whose application is not restricted to insurance, but is available in other contractual contexts as well. Pet. App. 5a-6a; *accord Gaylor*, 112 F.3d at 466.

The second element similarly does not represent a departure from pre-existing law. It has been clear at least since *Rush Prudential*, which the court below discussed at some length (*e.g.*, Pet. App. 3a-4a, 7a-8a), that state laws are saved only if they regulate insurers "'with respect to their insurance practices.'" *Kentucky Health Plans*, 123 S. Ct. at 1475 (quoting *Rush Prudential*, 536 U.S. at 466). A regulation of insurance practices, in turn, is one that "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Id.* at 1477, 1479. This aspect of the test is substantially similar to the first McCarran-Ferguson factor (*see id.* at 1474, 1478), albeit somewhat less stringent (*see id.* at 1477 n.3). And the Oklahoma bad-faith tort does not survive any version of this analysis; as the Tenth Circuit correctly held, "a law which defines the manner in which insurance claims should be processed" plainly "does not effect a change in the risk borne by insurers and the insured." *Gaylor*, 112 F.3d at 466; *see* Pet. App. 6a.

Thus, the only material changes that *Kentucky Health Plans* made in the saving-clause analysis were the elimination of certain factors and the clarification that a state law

must satisfy *both* elements of the two-part test to be saved. These changes in no way undermine the correctness of the Tenth Circuit's analysis of the Oklahoma tort, because the court of appeals twice concluded that *no* element of the saving-clause analysis weighed against preemption—neither the factors that the *Kentucky Health Plans* Court discarded nor those that it incorporated into the two-part test. Pet. App. 6a-7a (citing *Gaylor*, 112 F.3d at 466).

Petitioner's challenge to this string of holdings therefore rests not on any substantive change in the saving-clause analysis by *Kentucky Health Plans* or any other decision of this Court, but on a mere disagreement with the Tenth Circuit over that court's consistent interpretation of Oklahoma law. *See* Pet. 13-23. This narrow and localized dispute is not one of such national significance that this Court's review is required. And, of course, the Tenth Circuit decision also rested independently on its complete preemption analysis under Section 502(a), which was altogether unaffected by *Kentucky Health Plans*.

II. This Case Does Not Present a Suitable Vehicle For This Court To Resolve Conflicts Raised In Other ERISA-Preemption Cases

Although the Tenth Circuit in this case correctly and faithfully applied this Court's precedents in deciding that petitioner's claim is preempted both by ERISA § 514 *and* by ERISA § 502(a), other courts have permitted certain state-law causes of action against plan administrators to go forward. This Court's review is warranted in an appropriate case—several of which are the subject of currently pending petitions for certiorari—to resolve the conflicts created by

those divergent decisions.[6] This case, however, is not a suitable candidate for plenary review by this Court.

First, the petition devotes absolutely no argument to the complete preemption issue, which in most cases has jurisdictional significance and on which the circuit split is therefore the more pressing. Second, the petition devotes the bulk of its argument to an issue relating to Section 514(b)(2)(A)'s Insurance Saving Clause, an issue that is entirely different from the preemption questions under Section 514(a) on which the circuits have divided. Thus, the petition does not argue *either* of the pressing ERISA-preemption issues pending before this Court in a number of other cases.

A. The Petition Does Not Argue The Question Of Section 502(a) Preemption That It Purports To Present

The petition devotes virtually no argument to the question of complete preemption, which it presents merely as an afterthought. *See* Pet. at i. Complete preemption under Section 502(a), however, is the more important ERISA-preemption issue, both because it has jurisdictional significance that often requires it to be analyzed before "defensive" preemption issues that arise solely under Section 514(a), and because the circuit split over complete preemption is more developed. Yet the petition does not adequately present this question, and the Tenth Circuit resolved the complete preemption issue correctly and in accord with this Court's precedents. Therefore, although the complete preemption issue would merit this Court's review in an appropriate case, it is no basis for disturbing the judgment below.

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[6] Aetna Health Inc. is the petitioner in one such case presenting "complete preemption" issues. *Aetna Health Inc. v. Davila*, No. 02-1845 (docketed June 23, 2003).

The petition does not even mention complete preemption in its argument section. Although one of petitioner's argument headings does assert that the Oklahoma bad-faith tort does not conflict with ERISA's remedial scheme (Pet. 23), that section presents only some further discussion of the saving clause (*see id.* at 26, 27, 28), coupled with some naked policy arguments. *Id.* at 23-25. Furthermore, any assertion that a law that is excepted from the preemptive sweep of Section 514 cannot be completely preempted by the wholly independent Section 502(a)—as petitioner at one point appears to argue, *see* Pet. 26—would be contrary to this Court's cases, as well as to well settled preemption doctrine. *See, e.g.*, *Rush Prudential*, 536 U.S. at 377; *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 & n.9 (1993) ("No decision of this Court has applied the saving clause to supersede a provision of ERISA itself"); *see also Boggs v. Boggs*, 520 U.S. 833, 841 (1997).

Indeed, it is precisely because "complete preemption" under Section 502(a) and "defensive" preemption under Section 514(a) do not perfectly overlap that the complete-preemption question is so important. This Court's decision in *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), established that a claim that falls within the scope of ERISA § 502(a)'s exclusive set of remedies presents a federal question, even if it is pleaded only in state-law terms. *Id.* at 67. Thus, successfully establishing that at least one claim is completely preempted subjects that claim to removal pursuant to 28 U.S.C. § 1441, and in most cases gives the federal court supplemental jurisdiction over the entire action under 28 U.S.C. § 1367. Preemption pursuant to Section 514, by contrast, is only a defense and therefore has no effect on jurisdiction. *See, e.g.*, *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 13-14 (1983).

In many cases involving ERISA preemption of a state-law cause of action, the case may proceed in federal court

only if federal-question jurisdiction exists on *Metropolitan Life*'s complete-preemption rationale. In such cases, the court's resolution of the threshold issue of jurisdiction also resolves the merits, and the court need not reach the question of preemption pursuant to Section 514(a) or the two-step saving-clause analysis prescribed in *Kentucky Health Plans*.[7]

Not only is the complete preemption question more significant, it is also in more acute need of this Court's resolution. The circuits are sharply divided over whether a State may create a remedy in tort for injuries resulting from an HMO's benefits-administration decision. *Compare, e.g.*, *Elliot v. Fortis Benefits Ins. Co.*, Nos. 02-35080, 02-35133, __ F.3d __, __, 2003 WL 21768395, at *7-*8 (9th Cir. Aug. 1, 2003), *Fink v. Dakotacare*, 324 F.3d 685, 689 (8th Cir. 2003), *Marks v. Watters*, 322 F.3d 316, 318, 326 (4th Cir. 2003), *Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576, 582 (6th Cir. 2002), *Hotz v. Blue Cross & Blue Shield of Mass., Inc.*, 292 F.3d 57, 58, 60-61 (1st Cir. 2002), *and Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 270, 273-75 (3d Cir. 2001), *with Land v. CIGNA Healthcare of Fla.*, No. 02-15549, __ F.3d __, __, 2003 WL 21751247, at *6 (11th Cir. July 30, 2003), *Cicio v. Doe*, 321 F.3d 83, 102 (2d Cir. 2003), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, No. 03-69 (docketed July 14, 2003), *and Roark v. Humana, Inc.*, 307 F.3d 298, 309 (5th Cir. 2002), *petitions for cert. filed sub noms. Roark v. Humana, Inc.*, No. 02-1826 (docketed June 17, 2003), *Aetna Health Inc. v. Davila*, No. 02-1845 (docketed June 23, 2003), *and CIGNA Healthcare of Tex., Inc. v. Calad*, No. 03-83 (docketed July 15, 2003).

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[7] This case is not among the large group in which federal jurisdiction is based exclusively on the complete preemption doctrine, because diversity jurisdiction provided an additional, independent basis for removal. *See* App., *infra*, 1a-4a.

This Court currently has before it the petitions in *Davila*, *Cicio*, and *Calad*, each of which squarely presents the question of complete preemption. A holding of complete preemption in any of those cases would suffice to resolve most, if not all, of the uncertainty that federal courts of appeals currently face in dealing with the preemption of state tort remedies for errors in the administration of health benefits.

B. Petitioner Does Not Raise A Question Of Preemption Under Section 514(a) That Warrants Review

Not only do the legal arguments in the petition focus exclusively on the Section 514 issue, they focus only on narrow aspects of the doctrine that has developed under that section. As discussed above, the petition disputes the Tenth Circuit's interpretation of Oklahoma law and the effect of the saving-clause decisions that this Court has issued since this case was argued below. Neither of those arguments presents a conflict worthy of this Court's review.

All of the court of appeals cases that the petition cites in fact reached the *same* answer to the saving-clause question that the Tenth Circuit did in this case. *See, e.g.*, *Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003, 1008 (9th Cir. 1998), *cited in* Pet. at 11; *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1328 n.10 (5th Cir. 1992), *cited in* Pet. at 11-12; *see also Roark*, 307 F.3d at 313 (adhering to *Corcoran* on the Section 514 issue). Indeed, petitioner forthrightly admits that the Seventh Circuit has upheld Rule 11 sanctions against a party who, like petitioner, sought to carve out an exception to *Pilot Life*'s interpretation of the saving clause for his home State's law. *Smith v. Blue Cross & Blue Shield United*, 959 F.2d 655, 657, 659 (7th Cir. 1992) (rejecting the contention "that Mississippi's law applies generally while Wisconsin's law of bad faith is applied only to insurance contracts," and stating that "[n]o reasonable attorney having read *Pilot Life* and [*Metropolitan Life*] could manu-

facture a good faith argument as to why this suit should be brought"), *cited in* Pet. at 2-3.

The only contrary decisions on the saving-clause issue that petitioner presents were rendered by "a scattering of district courts," Pet. 3, and few of them remain good law even in the districts where they were issued. For example, one was reversed outright more than two years ago,[8] two were overruled by their regional circuit in the decision below,[9] and one is directly contrary to controlling circuit precedent and so can be disregarded.[10] This sparse assortment of questionable district-court authority does not present a meaningful conflict on the saving-clause issue that merits plenary review by this Court; indeed, if anything, it demonstrates that the courts of appeals are themselves resolving any intracircuit conflicts on the saving-clause issue consistently and correctly.

To be sure, *other* aspects of Section 514 preemption have caused a dispute in the lower federal and state courts, particularly with regard to the provision of health insurance. That dispute has centered on the meaning of the term "relate to" in Section 514(a), not on the interpretation of the saving

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[8] *Gilbert*, 276 F.3d at 1301, *rev'g in pertinent part* 122 F. Supp. 2d 1267 (N.D. Ala. 2000), *cited in* Pet. at 3.

[9] The Tenth Circuit's decisions in this case and in *Moffett*, discussed above at note 4, negate the contrary holdings of *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F. Supp. 2d 1202 (N.D. Okla. 1999), *cited in* Pet. at 2-3, and *Colligan v. UNUM Life Insurance Co. of America*, No. Civ.A. 00-K-2512, 2001 WL 533742 (D. Colo. Apr. 23, 2001), *cited in* Pet. at 3.

[10] *Compare Bast*, 150 F.3d at 1008 (holding Washington bad-faith claim *not* saved), *with Norman v. Paul Revere Life Ins. Co.*, No. C99-5463 JKA, 2000 WL 33316829 (W.D. Wash. May 12, 2000) (holding Washington bad-faith claim saved but not citing *Bast*), *cited in* Pet. at 3.

clause of Section 514(b)(2)(A) to which the petition is devoted. For example, the Pennsylvania Supreme Court has announced a categorical rule that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan" and hence are not preempted by Section 514(a). *Pappas v. Asbel*, 724 A.2d 889, 893 (Pa. 1998). The court reasoned that this Court had retreated from its earlier holdings regarding the breadth of Section 514(a)'s preemption clause. *Id.* at 892-93.

The holding in *Pappas* created a conflict with the decisions of this Court, *see, e.g.*, *Pilot Life*, 481 U.S. at 47-48 (finding "no dispute that the common law causes of action asserted in Dedeaux's complaint 'relate to' an employee benefit plan"), and of numerous other courts faithfully applying those decisions. *See generally* Brief for the United States as Amicus Curiae, *U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, No. 98-1836 (filed Dec. 17, 1999) (urging this Court to grant review and reverse *Pappas*). This Court vacated the Pennsylvania Supreme Court's judgment and remanded for reconsideration in light of *Pegram v. Herdrich*, 530 U.S. 211 (2001). *U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 530 U.S. 1241 (2001) (mem.). But on remand the Pennsylvania Supreme Court adhered to its erroneous decision. *Pappas v. Asbel*, 768 A.2d 1089, 1091 (Pa. 2001), *cert. denied sub nom. U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002).

Pappas continues to stand in sharp conflict to the run of cases interpreting Section 514(a). Several courts of appeals have declined to join the *Pappas* court in holding that this Court has retreated *sub silentio* from *Pilot Life*'s interpretation of Section 514(a). *See, e.g.*, *Roark*, 307 F.3d at 313. However, the Second Circuit has recently handed down just such a decision. *See Cicio*, 321 F.3d at 99, 102-03 & n.13. And at least one other State's supreme court has also departed from *Pilot Life*, albeit less sharply, by holding that a

"traditional" state-law claim for medical malpractice does not "relate to" an ERISA plan and thus is not preempted under Section 514(a). *See Eid v. Duke*, 816 A.2d 844, 850, 852 (Md. 2003).

At least two currently pending petitions—those in *Roark*, No. 02-1826, and in *Cicio*, No. 03-69—seek this Court's resolution to this division over Section 514(a). In a suitable case, plenary review of the Section 514(a) question might well be warranted. Of course, as noted in Aetna's brief in *Roark*, it would be appropriate to decide the Section 502(a) issue first, because in many cases—including both *Roark* and *Cicio*, but not this case—federal jurisdiction was based on complete preemption and that doctrine therefore necessarily comes first in the analysis. *See* Brief for Respondent Aetna Health Inc. at 3-4, *Roark v. Humana, Inc.*, No. 02-1826 (filed July 7, 2003).

But even presuming that the question of preemption under Section 514(a) continues to warrant this court's review, the argument based on the conflicting interpretations of Section 514(a) is not presented in this case. The petition never argues that Oklahoma's cause of action for bad faith does not "relate to" the ERISA plan; it contends only that the cause of action is nonetheless saved as a regulation of insurance. Indeed, as the Tenth Circuit noted, in the lower courts it was "*undisputed* [that] Oklahoma's bad faith law falls within [ERISA's] language preempting state laws related to 'any employee benefit plan.'" Pet. App. 5a (emphasis added). Petitioner's briefs in the court of appeals were devoted to the complete preemption doctrine, the impact of the saving clause (including the contention that the saving clause negates the complete preemption doctrine), and the proposed formulation of a federal common law remedy to supplement those available under Section 502(a). Petitioner did not rely on *Pappas* or make the argument that the Pennsylvania Su-

preme Court erroneously accepted in that case. Nor does she make that argument here.

Accordingly, this case is not a suitable vehicle to resolve the dispute over Section 514(a), and the questions relating to Oklahoma common law and Section 514(b)(2)(A) that the petition does present are not the subject of such a well developed conflict—or, indeed, any meaningful conflict—among the lower courts.

* * *

The petition in this case does not present the cert-worthy question of ERISA "complete preemption" under Section 502(a) that is pending before this Court in *Davila*, *Calad*, and *Cicio*. Nor does federal jurisdiction in this case turn on the applicability of complete preemption; it is unquestioned that this case satisfies the requirements for diversity jurisdiction, which the removal papers expressly invoked. *See* App., *infra*, 1a-4a. Further, this case does not present the question of "defensive" preemption under Section 514(a) that is currently pending before this Court in *Roark*—a question that might be cert-worthy in an appropriate case, though it is not well presented in *Roark* itself because the petitioner in *Roark* has ignored the necessarily antecedent issue of jurisdiction under the "complete preemption" doctrine. Instead, the only issue that this case presents is whether ERISA's saving clause permits a plaintiff to sue her plan administrator in tort for bad faith, a contention that the circuits have unanimously rejected in fidelity to this Court's holding in *Pilot Life*. For those reasons, this Court need not hold the petition pending its disposition of *Davila*, *Calad*, *Cicio*, and *Roark*, but rather should deny the petition outright.

CONCLUSION

The petition for a writ of certiorari should be denied. In the alternative, the petition should be held pending the Court's consideration of the petitions in *Davila*, *Calad*,

Cicio, and *Roark*, and disposed of as appropriate in light of the resolution of those cases.

Respectfully submitted.

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August 26, 2003

APPENDIX

APPENDIX A

FILED

JUL 07 2000

SALLY HOWE SMITH,
COURT CLERK
STATE OF OKLA.
TULSA COUNTY

FILED

JUL 7 2000

Phil Lombardi, Clerk
U.S. DISTRICT COURT

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA

SALLEE A. CONOVER,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 00CV0559B (J)
	)	
AETNA US HEALTHCARE, INC.	)	(formerly Tulsa County District Court Case No. CJ-2000-2700)
	)	
Defendant.	)	

NOTICE OF REMOVAL

Defendant Aetna US Healthcare, Inc. ("Aetna" or "Defendant"), pursuant to 28 U.S.C. §§ 1441-1448, hereby removes this case to the United States District Court for the

Northern Ditrict of Oklahoma. In support of removal Aetna states as follows:

I. 29 U.S.C. § 1332.

1. Aetna is the defendant in a state court action brought against it by Plaintiff in the District Court of Tulsa County, State of Oklahoma, entitled Sallee A. Conover v. Aetna US Healthcare, Inc., Case No. CJ-2000-2700.

2. This is a civil action where the matter in controversy exceeds the sum or value of $75,000.00, exclusive of interest and costs, and is between citizens of different states. Federal jurisdiction therefore exists under 28 U.S.C. § 1332.

3. At all times from the filing of this action through and including the present, Aetna is and has been a corporation duly organized and existing under the laws of the State of Pennsylvania with its principal place of business in the State of Pennsylvania. Aetna has not been incorporated under the laws of the State of Oklahoma and does not have its principal place of business in the State of Oklahoma. Aetna is therefore considered a citizen of the State of Pennsylvania for the purposes of diversity jurisdiction under 28 U.S.C. § 1332(c)(1).

4. Plaintiff's petition states that she resides in Tulsa County, Oklahoma. On information and belief, at all times from the filing of this action through and including the present, plaintiff is and has been a resident of the State of Oklahoma. Plaintiff is not and has not been a resident of the State of Pennsylvania.

5. Plaintiff's petition alleges intentional breach of contract and breach of good faith and fair dealing by an alleged insurance carrier. Plaintiff's petition requests both actual damages and punitive damages. In violation of 12 O.S. § 2008(A)(2), plaintiff's petition seeks damages in excess of fifty thousand dollars ($50,000.00) for "each instance." The petition asserts two counts, so on its face, the petition ostensi-

bly seeks in excess of $100,000.00, exclusive of interest and costs.

6. Additionally, the petition seeks an unspecified amount of extracontractual and punitive damages. The Court must consider this demand in determining whether the amount in controversy exceeds the jurisdictional amount.

7. Aetna denies that it is liable to the plaintiff. However, plaintiff is seeking to maximize her recovery, and it is reasonable to conclude that plaintiff seeks in excess of $75,000.00, exclusive of interest and costs. Awards in lawsuits for alleged breach of insurance contract and bad faith frequently exceed the sum or value of $75,000.00, exclusive of interest and costs. Additionally, punitive awards alone frequently exceed the jurisdictional amount. It therefore does not appear to a legal certainty that the plaintiff could not recover in excess of the jurisdictional amount under 28 U.S.C. § 1332.

8. The matter in controversy exceeds the sum or value of $75,000.00, exclusive of interest and costs.

II. 29 U.S.C. § 1132(e)(1).

9. This is an action by a beneficiary of an employee benefit plan as defined under 29 U.S.C. § 1002(3), to recover benefits. Federal jurisdiction therefore exists pursuant to 29 U.S.C. § 1132(a)(1)(B) and § 1132(e)(1).

10. Plaintiff has been an employee of Harcourt General, Inc. ("Harcourt"). Harcourt established various plans, funds and programs, including a plan for disability benefits issued by Aetna ("Plan"), for the purpose of providing benefits to its participants or their beneficiaries. These plans are governed by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001-1461 ("ERISA"), and plaintiff is a participant in the Plan.

11. Plaintiffs petition expressly seeks the recovery of benefits. All benefits provided to plaintiff in connection with

her employment were provided to her through ERISA covered plans, and specifically through the Plan. Copies of the relevant portions of various documents for the Plan are attached hereto as Exhibit "A" and made a part hereof).

12. As a suit by a participant and beneficiary to recover benefits from an ERISA covered plan, plaintiff's lawsuit is governed by 29 U.S.C. § 1132(a)(1)(B), which provides an exclusive federal cause of action for resolution of such disputes. Therefore, this case is removable under 28 U.S.C. § 1441(b), in accord with *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63, 95 L.Ed.2d 55, 62 (1987).

13. Plaintiff's state law claims, theories, and requests for relief relate to her claim for benefits and are preempted by ERISA. *See Pilot Life Ins. Co. v. Taylor*, 481 U.S. 41, 95 L.Ed.2d 39 (1987). In *Gaylor v. John Hancock Mut. Life Ins. Co.*, 112 F.2d 460 (10th Cir. 1997), the plaintiff argued that both Oklahoma statutory and decisional law was saved from ERISA preemption. *See* plaintiff-appellant's briefs in *Gaylor*, attached hereto as Exhibit "B" and made a part hereof. The Tenth Circuit rejected those arguments in its published decision which is controlling herein.

III. 28 U.S.C. § 1331.

14. This is a civil action arising under the laws of the United States. Federal jurisdiction therefore exists under 28 U.S.C. § 1331.

IV. Process

15. The aforementioned action was commenced on June 6, 2000, on which date plaintiff filed her petition in this action with the state court. Service was accomplished by certified mail on June 8, 2000. This notice of removal is therefore timely filed under the provisions of 28 U.S.C. § 1446, and this action is removed under 28 U.S.C. §§ 1441-1448.

16. Copies of all process, pleadings and orders served upon Defendant in the state court action are attached hereto as Exhibit "C" and made a part hereof.

Dated this 7th day of July, 2000.

Respectfully submitted,

/s/

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Henry D. Hoss, OBA # 11354
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CERTIFICATE OF SERVICE

I hereby certify that on the 7th day of July, 2000, the foregoing was filed with the Court Clerk for the United States District Court for the Northern District of Oklahoma and that a true and correct copy was hand-delivered to:

Sally Howe Smith
Court Clerk
District Court of Tulsa County
200 Courthouse
500 South Denver
Tulsa, OK 74103-3844

and mailed, postage prepaid and addressed to:

Maynard I. Ungerman
Stephen J. Greubel
1323 E. 71st Street
Suite 300
Tulsa, OK 74136

/s/
Mark D. Spencer

[Exhibits A & B to Notice of Removal Omitted]

* * *

[Excerpt of Exhibit C to Notice of Removal]

IN THE DISTRICT COURT IN AND FOR TULSA COUNTY STATE OF OKLAHOMA

FILED

JUN - 6 2000

SALLY HOWE SMITH,
COURT CLERK
STATE OF OKLA.
TULSA COUNTY

SALLEE A. CONOVER,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No.: CJ 2000-02700
	)	
AETNA US HEALTHCARE, INC.	)	Judge:
	)	
	)	
Defendant.	)	

PETITION

COMES NOW the Plaintiff, Sallee A. Conover (hereinafter referred to as "Conover") and for her cause of action against the Defendant, Aetna U.S. Healthcare, Inc. (hereinafter referred to as "Aetna") alleges and states as follows:

FIRST CAUSE OF ACTION

Intentional Breach of Contract

1. Plaintiff is a citizen and a resident of the city of Tulsa, County of Tulsa, State of Oklahoma.

2. Defendant Aetna is a Corporation formed and existing under the laws of the State of Oklahoma authorized to issue medical and health insurance policies and authorized to do business and is doing business within the State of Oklahoma.

3. This Court has both venue and jurisdiction over the parties and subject matter of this action.

4. Plaintiff is a named beneficiary under a "certificate of coverage" with Defendant Aetna pursuant to a policy issued through her employer Harcourt General, Inc. Group control number 657241 for managed disability benefit plan. Said policy was issued with her employer as a part of the benefits of said employment but Plaintiff paid for the premiums personally.

5. That as a result of an accident incurred by Plaintiff on November 12, 1997, Plaintiff was receiving payments under said policy for disability.

6. That thereafter on August 12, 1999, the Plaintiff received a notification from Defendant that effective June 30, 1999, all disability payments to Plaintiff would cease.

7. Said determination was arbitrary, capricious and in violation of the terms of the agreement between Plaintiff and Defendant and further, efforts to obtain evidence claimed by Aetna as to the right to terminate said payments was withheld for a substantial period of time by Defendant from Plaintiff and said evidence did not justify terminating said policy.

8. Thereafter and in accordance with the contractual provisions, Plaintiff appealed the determination made by Defendant.

9. Plaintiff appealed the determination made by Aetna pursuant to the notifications given by Defendant to Plaintiff. As part of said appeal, Plaintiff submitted to Defendant Aetna, rulings of the Social Security Administration that she is still disabled as well as affidavits to the same affect. Defendant has refused to answer any further correspondence relative to said matter and refuses to make a ruling on Plaintiff's appeal.

10. All of said conduct is in direct violation of the contract in effect between Plaintiff and Defendant.

WHEREFORE, Plaintiff prays that on this her first cause of action that she be awarded recompense for all past disability payments due, all expenses incurred as a result of having to purchase other insurance, and that a permanent Order be entered requiring Defendant to continue to make said payments pursuant to the contract with Plaintiff, that Plaintiff be awarded her attorneys fees herein; interest and costs.

SECOND CAUSE OF ACTION

Breach of good faith and fair dealing by Insurance carrier

Plaintiff reincorporates and restates all matters here and before set forth herein and incorporates them as part of this second cause of action.

11. Plaintiff believes and therefore alleges that Defendant deceitfully and in bad faith and contrary to fair dealing has ceased and refused to pay Plaintiff the sums due her under said contract as a result of her physical disability.

12. That in addition thereto Defendant has refused to answer correspondence or telephone calls of Plaintiff and/or her attorney and refused to comply with the terms of their own agreement relative to a review of any termination of benefits.

13. Defendant has failed to deal fairly and in good faith with this Plaintiff commencing with the termination of her

benefits; by refusing to allow her for a lengthy period of time to have access to a report which Defendant claimed denied grounds for Plaintiff's payment of medical benefits; by not attempting in good faith to effectuate a prompt, fair and equitable payment of sums due to Plaintiff; by denying payment and claiming said payment was not medically necessary when in reality it was based on Plaintiff s condition and as evidenced by the Social Security Administration classifying Plaintiff as disabled; and by Defendant failing to perform its respective duties to see the Plaintiff was timely paid.

14. By reason of the gross, willful and wanton negligent, deceitful misrepresentation, bad faith and oppressiveness exercised by this Defendant, Plaintiff believes and therefore alleges that she has suffered substantial economic loss, humiliation, anguish, mental and emotional pain and suffering all in excess of fifty thousand dollars.

15. Plaintiff further alleges that she is entitled to exemplary or punitive damages in order to make an example of this Defendant as and for punishment and to act as a determent to others similarly situated.

WHEREFORE as to Plaintiff's second cause of action, Plaintiff prays for both actual and punitive damages in an amount in each instance in excess of fifty thousand dollars against this Defendant, together with interest, costs and attorneys fees as provided for by law.

/s/

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Attorney for Plaintiff

* * *

(4)

Supreme Court, U.S.
FILED
OCT 2 2 2003
OFFICE OF THE CLERK

No. 02-1864

In The

Supreme Court of the United States

SALLE A. CONOVER,

Petitioner,

v.

AETNA US HEALTHCARE, INC.,
and AETNA LIFE INSURANCE COMPANY

Respondents.

On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Tenth Circuit

SUPPLEMENTAL BRIEF FOR PETITIONER

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7 pp

SUPPLEMENTAL BRIEF FOR PETITIONER

Pursuant to this Court's Rule 15.8, petitioner Sallee A. Conover respectfully submits this supplemental brief to call the Court's attention to four newly decided cases that reemphasis this Court's need to grant certiorari. Those cases are *Kidneigh v. Unum Life Insurance Company of America*, ___ F.3d _____ , 2003 W.L. 22273320 (10th Cir., Colo. October 3, 2003; *Elliot v. Fortis Benefits Insurance Company,* 337 F.3d 1138)9th Cir. Mont. 2003; *Rosenbaum v. Unum Life Insurance Co. of America*, 2003 W.L. 2207855 (E.D. Pa. 2003); and *DiFelice, Jr. v. Aetna U.S. Healthcare*, 2003 W.L. 22346402 (C.A. 3 Pa. 2003).

1. In *Kidneigh*, the Tenth Circuit considered a case very similar to the case at bar and once again decided in the majority opinion that a state insurance bad faith law is both directly preempted because it does not come under the insurance savings clause, 29 U.S.C. § 1144(a), (b)(2)(B) and further that it conflicts with ERISA's civil enforcement provision, 29 U.S.C. § 1132(a)(1)(B). The majority of the opinion hones in on the conflict preemption rather than the direct preemption issue but acknowledges that its decision is based upon Supreme Court *dicta* rather than any case holding. The majority opinion acknowledges "[t]he Supreme Court has strongly indicated in dicta that a state law falling within ERISA's savings clause . . . would still be preempted merely by providing remedies beyond those prescribed in ERISA." Opinion at Page 3.

Judge Henry of the Tenth Circuit filed an opinion concurring in part and dissenting in part. Judge Henry concurs with that portion of the opinion where the Court determined under current case law interpretation a state law that provides remedies beyond those spelled out in ERISA is preempted under a conflict preemption analysis. Acknowledging that precedent is *dicta* but the Court is nonetheless compelled to follow those pronouncements. "This Court considers itself *bound* by a Supreme Court *dicta* almost as firmly as by the Court's outright holdings, particularly when the dicta is recent and not enfeebled by later statements." Gaylor v. United States, 74 F.3d 214, 217 (10th Cir. 1996)" (Emphasis added by Court)(Opinion at Page 8). However, Judge Henry reasoned that direct preemption did not apply to this state insurance bad faith claim based upon more recent teachings by this Court. Judge Henry then makes the following observation in his conclusion:

> "ERISA was enacted as a balanced statute, offering certain protection to insurers while securing protection for insured patients who are at their most vulnerable when they suffer medical harm. Through the insurance savings clause, Congress specifically authorized the states to continue regulating the business practices of insurance companies. State regulation of insurance is an undeniably proper state function that permits states to respond to the specific aspects of their policy problems better than the one-size-fits-all

> approach the majority's reading emphasizes. The majority's approach helps dismantle the protective system devised by Colorado's legislature and courts for Colorado's citizens." Opinion at Page 19.

The Judge then goes on to state that he is bound by binding precedent of the Supreme Court and the Tenth Circuit and thus the claim is barred by conflict preemption but he believes that the majority's direct preemption approach analysis is unnecessary and probably incorrect as a matter of law.

2. In the case of *Elliot v. Fortis Benefits Insurance Company*, 337 F.3d 1138 (9th Cir. Mont. 2003), the Ninth Circuit appears to completely skirt the direct conflict preemption analysis that has plagued advocates for state insurance bad faith rights until recent pronouncements by this Court. In doing so, it appears that the Ninth Circuit believes that state insurance bad faith laws may now be saved from ERISA direct preemption. It reasons that the state law would nonetheless be preempted under a conflict preemption analysis much as the Tenth Circuit does.

3. In *Rosenbaum* the trial court comes to a different conclusion utilizing what petitioner believes is the appropriate statutory construction approach. Simply put the ERISA statute specifically saves insurance law. There is a general enforcement provision that up to this point has been utilized, and more and more as this Court

has receded from its strict McCarran-Ferguson test, as a way of defeating causes of action for extracontractual benefits. Judge Newcomer found three separate reasons why under appropriate statutory interpretation the savings clause should trump any conflict preemption analysis. First is that the savings clause is unambiguous. It being unambiguous, it clearly indicates the legislature's intent to save all state insurance laws without any further reservation. Second, the Court finds that this court's application of the doctrine that "expression of one thing implies the exclusion of another" as applied in *Pilot Life* and *Rush* contradicts Congress' express intent found in ERISA's plan language to save all state insurance law. Simply put the *implied intent* found in ERISA's Section 514(b)(2)(A) conflicts with Congress' *express intent* to save all state insurance law. Thirdly, the Court finds that conflict preemption analysis disregards the basic presumption against implied preemption, the matter already discussed by the petitioner in her initial petition.

4. Finally in *DiFelice, Jr.*, we are again presented with another case that shows why from a policy reason this Court should grant certiorari and should grant it in this case. Circuit Judge Becker's concurring opinion is an excellent analysis of the ERISA law and could well serve as a brief for petitioner on the merits of this case. As Judge Becker shows in his opinion the effect of the current ERISA law has a perverse effect due to the unavailability of extracontractual damages. It basically discourages the beneficiary from seeking the rights that ERISA was designed to protect and at the same time

encourages the insurer to deny those benefits without fear of any repercussions except for paying the benefits that should have been paid in the first place.

Petitioner is aware that this Court is considering other cases in conference but all of those cases deal with the availability of damages under a medical malpractice theory and really skirts the true problem that we have in ERISA today.

As a result of the ERISA scheme clever lawyers and courts have attempted to determine when a beneficiary is harmed by a claims denial decision and when the beneficiary is harmed as a patient in a medical decision. That is an interesting question but one that really ignores the true question that this Court should decide in light of the way the law has developed. First, it appears that any state insurance bad faith law that has developed such as Oklahoma's or is a part of a statutory scheme would most certainly be saved under the less restrictive test than that applied in *Pilot Life*. Second, is a state law that is directly saved under the ERISA statute nonetheless preempted under a conflict preemption analysis. Those two central and vital questions that demand answering will not be addressed in the other cases under consideration by this Court. Those questions will continue to be the subject of intense litigation and even more diversion until answered.

Respectfully Submitted,

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October 21, 2003